Health Care Financing

Research & Demonstration Series

Report No. 2

Second Surgical Opinion Medicare Demonstration: Greater New York

Department of Health, Education & Welfare • Health Care Financing Administration

MEDICARE SECOND SURGICAL OPINION

DEMONSTRATION PROJECT

by

Blue Cross and Blue Shield
of Greater New York

This report is made pursuant to contract number 600-77-0122 between the Health Care Financing Administration, Department of Health, Education, and Welfare and Blue Cross and Blue Shield of Greater New York. The amount charged to the Department of Health, Education, and Welfare for the work resulting in this report (inclusive of the amounts so charged for any prior reports submitted under this contract) is $100,881. The name of the person employed by the contractor, with managerial responsibility for such work, and for the content of the report is Ms. Patricia A. O'Connor.

The Project Officer for this contract is Ms. Trudi W. Galblum, a staff member within the Health Care Financing Administration, Office of Policy, Planning and Research. The views and opinions expressed in the report are the contractor's and no endorsement by the Health Care Financing Administration or Department of Health, Education, and Welfare is intended or should be inferred.

ACKNOWLEDGEMENTS

The development of the Medicare Part B Second Surgical Opinion Experiment has been an extensive and complex undertaking requiring input from talented individuals throughout the Corporation.

While it is not feasible to identify each, and describe their particular contribution, it should be noted that without their efforts, this Experimental Program would not have been realized.

Particular recognition is in order for Mr. George Schirm who worked tirelessly and enthusiastically to design a system that would circumvent the many problems presented in this Program.

In addition, Ms. Brenda Prescott is thanked for her assistance in interfacing the activities of the Medicare Operations Division with the Experiment.

Most significantly, the Second Opinion Referral Center Staff should be cited for their perserverence under the pressures imposed upon them during this developmental activity, which was further compounded by the three month absence of the Center's supervisor, due to severe illness.

Finally, a special note of appreciation for the patience and capabilities of Joseph Barber who typed this Protocol through its endless revisions.

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* * *

INTRODUCTION

Health care costs are rising much more rapidly than the overall rate of inflation in the economy.

While the extent of health care expenditures allocated for surgical care is not clear, public attention is beginning to focus on the possibility that excessive surgery is both inflating costs unnecessarily and is harming some patients. The House Subcommittee on Oversight and Investigation in 1975 issued a report regarding potential overuse of surgical procedures, estimating 2.4 million unnecessary operations annually, with an associated loss of four billion dollars and 12,000 lives.

We question the premises upon which estimates of such magnitude are based, but the public concern about the issue of excess surgery cannot be denied.

The literature is filled with studies demonstrating relationships between surgical rates and geographic area, facilities and resources, socioeconomic status and financial arrangements. Surgical indices have been shown to vary in a direct and indirect, complex and simple relationship with numerous variables which have little to do with diagnoses and medical conditions. Even when all known clinical characteristics are accounted for, the fact is that large variances exist for both the total number of surgical operations and specific categories of procedures.

It seems in the interest of the public then, to examine expenditures under governmentally financed programs to ascertain provisions which would result in a more economical and efficient utilization of services. With this in mind, the Health Care Financing Administration (HCFA) competitively awarded Contracts in September of 1977, to Blue Cross and Blue Shield of Greater New York and to Blue Cross and Blue Shield of Michigan to develop and implement Second Surgical Opinion Programs for eligible Medicare Part B Beneficiaries in their respective Carrier service areas.

The purpose of this Experiment is to provide data necessary to determine whether coverage of Second (and Third) Surgical Opinions produces a net cost savings and/or lower morbidity and mortality rates among the Medicare population.

The Experimental Benefit will be made available to approximately 1.5 million Part B Medicare Beneficiaries (including the disabled) who reside in and seek medical care from physicians in the 17 southern Counties of New York State. This includes one (1) County in which the Contractor is not the Medicare Carrier.

The Experiment is designed to extend three (3) years; May 1978 to May 1981. The total utilization projected for the test period is approximately 3,000 Beneficiaries.

The Program is voluntary. Beneficiaries are encouraged, but not required, to obtain a second and if desired a third opinion prior to undergoing elective surgery. Hospital benefits, otherwise available to the Beneficiary, will not be affected should the Beneficiary decide to undergo surgery regardless of whether the Second/Third Opinion confirms or fails to confirm the need for surgery.

As an incentive to encourage use of this Benefit, the coinsurance and deductible requirements have been waived. Second/Third Opinions are available with no out-of-pocket expense to the Beneficiary. Additionally, any laboratory tests or x-rays that might be ordered relative to these opinions will also be reimbursed at 100%.

BCBSGNY negotiated a six (6) month Pre-Implementation Phase, beginning November 1, 1977, during which time:

- A Consumer/Provider Education and Marketing Program was designed;
- Consultant Cooperation was obtained;
- Special Referral Center Procedures were developed;
- Claims Processing Procedures were established;
- Data Collection Activities were finalized, and;
- Reimbursement Methodologies were developed.

This Pre-Implementation or planning phase was scheduled to terminate on May 1, 1978, at which time Phase II or the Implementation Phase was to commence; wherein Second/Third Opinion Services would be available to the treatment group.

Some delays in the publication of the Systems Notice in the Federal Register has postponed this implementation date to May 22, 1978. Appropriate minor adjustments have been made by the Contractor, particularly as relates to our advertising campaign, to accommodate this date change.

This Protocol is now submitted as documentation of the activities that have occurred during the Pre-Implementation Phase, as well as those that are projected for the duration of the Contract.

DEFINITION OF TERMS

Elective Surgery

For the purpose of this study, Elective Surgery will be defined as "Surgery performed on an inpatient or outpatient hospital basis or in a freestanding ambulatory surgical center which is not considered an emergency or life threatening and is subject to the choice or decision of the patient or physician." [1]

Eligible Population

Part B Medicare Beneficiaries who:

° Reside in and seek medical care from surgeons in one of the following Southern Counties of New York State.*

Bronx	Nassau	Rockland
Columbia	New York	Suffolk
Delaware	Orange	Sullivan
Dutchess	Putnam	Ulster
Greene	Queens	Westchester
Kings	Richmond	

° Have arranged their second opinion request through the Referral Center of Blue Cross and Blue Shield of Greater New York prior to the submission of any claim for second opinion services.

° Have seen a surgeon within 4 months prior to their request for a second surgical opinion.

Though we originally intended to provide access to the benefit only for those patients who had seen a surgeon within the last four months, it was felt that this cut-off point could discriminate against individuals who validly might benefit from a second professional evaluation, even though more than 4 months has elapsed since their last office visit. This would particularly relate to Beneficiaries with irreversible disease entities such as cataracts, hernias, uterine prolapses, degenerative joint diseases, etc., for whom an additional office visit, when surgery had previously been discussed or recommended, would not be indicated.

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[1] Department of Health, Education, and Welfare, SSA-RFP 77-0282, "Scope of Work," Second Surgical Opinion Program, May 1977, P.6.

* This includes the Medicare disabled and involves approximately 1.5 million Beneficiaries.

Subsequently, it has been determined that those Beneficiaries who have seen a surgeon within one year can be eligible for the benefit, after the individual case is reviewed by the supervisor with whom the referral analyst will discuss all second opinion requests falling into this category.

PRESSO

Program for Elective Surgical Second Opinion...In operation for over two (2) years, it has been the modality for providing more than 2,000 second opinions, and is available to approximately five million BCBSGNY subscribers.

Routine Second Opinion Benefit

On Nov. 1, 1977, Under Secretary, Hale Champion, announced that HEW is going to "begin a major effort to encourage the American public, and especially our own Beneficiaries, to seek a second physician's opinion", when surgery is being considered.

"Second opinions are "physician's services" within the meaning of section 1861(q) of the law and implementing regulation. There has been no specific policy instruction concerning their coverage issued in the past nor any concerted effort until now to employ this mechanism under Medicare as a means to reduce unnecessary surgery. The current effort will emphasize that second physician opinions pertaining to potential surgeries are not only covered but are recommended and encouraged."*

This national thrust has added some degree of complexity to Program development.

Every attempt has been made in the Demonstration's advertising and educational campaign to distinguish between the existence of the routine benefit and the three year Demonstration Program particularly as relates to waiving of the coinsurance and deductible requirements as well as the need to arrange consultations through the Referral Center.

* Department Of Health, Education and Welfare; Health Care Financing Administration; Part B Intermediary Letter No. 77-40.

First Opinion Surgeon

Refers to any surgeon seen within 120 days prior to the request for a second opinion and with whom the possibility of elective surgery was discussed, or from whom a recommendation for elective surgery was received. This surgeon does not have to practice in the Contractor's Service Area. His surgical specialty must, however, be validated in the Medical Directory of the state in which the first opinion was rendered.

Although it has been our experience that some patients request a Second Surgical Opinion after a surgical recommendation from an Internist or General Practitioner, the Contractor will make Second Surgical Opinions available only after an individual has seen a surgeon who could or would perform the surgery, were it to be done.

It has been discussed that by employing this criteria to be eligible for the Benefit, we are requiring that some patients be subject to an additional physician visit (a surgeon) after having already seen a physician (non-surgeon).

We recognize that this can be:

° A financial hardship for some individuals, as well as;

° A frustrating experience for those who claim they have "already had a surgical recommendation".

Despite these considerations, it has been determined, for the purpose of this study, that a First Opinion Physician be a surgeon.

Second Opinion Surgeon

Refers to one of the approximately 1,500 Board Certified surgical specialists cooperating on the BCBSGNY Second Opinion Panel, who:

° Examines the Beneficiary after they have registered with the Center.

° Evaluates their need for elective surgery regardless of whether the First Opinion Surgeon actually "recommended" surgery, or merely "discussed" it.

° Provides reports of their findings.

° Agrees not to treat the patient or perform surgery.

° Agrees to accept a fee on assignment of up to $50.00.

Third Opinion Surgeon

The Third Opinion Surgeon meets all of the definitions outlined for the Second Opinion Surgeon.

Additionally, Third Opinions will be available to the Beneficiary regardless of whether the First Opinion and Second Opinion Surgeon's recommendations differ or are the same.

EXAMPLE

FIRST OPINION	SECOND OPINION	THIRD OPINION
Surgery Recommended	Surgery Recommended	Eligible
Surgery Recommended	Surgery Not Recommended	Eligible
Surgery Not Recommended	Surgery Not Recommended	Eligible

Third opinions will be available within the same time frame as second opinions, i.e.: within four months after having seen a surgeon, or in some cases within 1 year if the diagnosis and/or symptoms so warrant.

Fourth opinions are not provided under the Experiment.

SECOND OPINION REFERRAL CENTER

The Second Opinion Referral Center is BCBSGNY's organizational unit responsible for processing second opinion requests.

Established in January of 1976, the Referral Center is designed to obtain and channel Program information, serving as the catalyst for the efficient delivery of the Benefit.

During the course of the Medicare Experimental Program, BCBSGNY will continue to provide the PRESSO Program for its subscribers as it concurrently modifies procedures and policies to efficiently service the new eligible population.

These expanded or revised procedures will be described in depth in the body of this report. Similarly, the responsibilities and functions of the Center's staff will be diagrammatically expressed, and narratively discussed in detail under the following headings:

° Flow Charts

° Policies and Procedures

° Data Collection Tools

Briefly, however, the staffing and functions of the Referral Center are as follows:

° The Program is administered by a Coordinator, who additionally functions as the Project Director for the Medicare Experiment.

° A Nurse Supervisor has the responsibility for the daily functioning of the Center as well as inputting into clinical decision-making and interpretation of Program policy and procedures.

° A Secretary/Receptionist.

° Four (4) Referral Analysts, one of whom has been designated as a Control Clerk for the purpose of the Experiment. These individuals, as the Center's primary contact with the public, have familiarity with medical terminology, extensive knowledge of Plan business, as well as qualifying as courteous and informed representatives of BCBSGNY.

In addition to being responsible for the referral process, the analysts also maintain statistical data on those persons who utilize the benefit, as well as those who are ineligible for having sought and received a second opinion outside of the Referral Center. (The Policy and Procedures portion of this Protocol further discusses this latter issue.)

Referral Process

The purpose of the following, is to outline the activities of the Referral Center analysts. Rationale for some of the steps in this synopsis may not always be apparent and references may be made to data collection tools with which the reader may be unfamiliar.

However, to introduce an explanation for each approach chosen and each tool used, could at this point, be confusing. All are developed in depth in the body of this document or in the "Policies and Procedures", and "Data Collection" sections.

Phase I

- During the initial telephone interview with the Beneficiary, the analyst will compile necessary data on the Patient Intake Form and using available resources, determine that the Beneficiary has Part B Medicare.

- After establishing eligibility, the analyst will provide the Beneficiary with the names of three (3) Board Certified Panel surgeons, who, whenever possible, are geographically convenient and in the same surgical specialty as their first surgeon. (Beneficiaries are able to see a pre-selected surgeon of their own choosing provided he is on the second opinion panel and arrangements for this consultation are made through the Second Opinion Center.)

- The analyst will explain the First Opinion Surgeon Form to the Beneficiary, asking him if he has any objection to our mailing it to his primary surgeon. The analyst will stress the importance of the First Opinion Surgeon Form, and encourage as many Beneficiaries as possible to permit its release.

- In concluding the initial telephone interview, the analyst will convey the essence of the following paragraph to the Beneficiary asking the Beneficiary if he wishes a copy of his Patient Intake Form.

  "The authority for collecting the above information is contained in section 402 (a) of the 1967 Amendments to the Social Security Act as amended by section 222(b) of the 1972 Amendment to the Social Security Act, P.L.92-603. Disclosure of such information is voluntary.

  The information collected in this form will be used to conduct referrals and to evaluate the impact of the program. If individuals do not provide the information, they may not be able to obtain a consultation with waivers of co-payment and deductible requirements."

- The Beneficiary is then advised to again call the Referral

Center after making their appointment for the second opinion consultation. (Upon request by the Beneficiary, the analyst will schedule the appointment.)

Phase II

- After receipt of the return call, the purpose of the claim form will be explained to the Beneficiary and he will be advised to call the Center should the surgeon order laboratory tests or x-rays to be performed outside his office.

- The analyst will then contact the Second Opinion Surgeon to confirm the appointment; appropriate claim forms and an instruction letter will then be released to the Beneficiary.

- The analyst also will provide access to a third opinion, should it be requested, using the same procedure as outlined above.

PANEL SPECIALISTS AND RECRUITMENT ACTIVITIES

Background

More than 2000 American Board Certified Surgical Specialists were Panel members of the Blue Cross and Blue Shield of Greater New York Program for Elective Surgical Second Opinion at the time of the awarding of the RFP.

Enrollment activities had been in progress since October of 1975, three (3) months before the Program began.

The bulk of physicians had been enrolled following invitation by mass mailing to approximately 6000 Board Certified surgeons practicing in the lower 17 counties of New York, as well as New Jersey and Connecticut (the area which the Contractor serves under its basic contract).

Since participation on the Panel was voluntary, it was the Contractor's belief that surgeons who did not agree to participate initially, did so for definitive reasons, i.e.:

- the reimbursement fee was inadequate;
- the forms' completion required was time consuming;
- the terms of the agreement were confining, particularly as they relate to the surgeon being required not to treat the patient or perform surgery, and lastly;
- the concept perhaps was not one that they wished to support.

As there were no programmatic changes relating to these objections planned for the Medicare Experiment, it was decided not to resolicit surgeons. To do so would be costly and time consuming, and of most concern, probably non-productive.

In addition, it was believed that there was adequate representation in terms of numbers and disciplines to service the anticipated volume of Medicare Beneficiaries seeking Second Surgical Opinions over the next three (3) years.

It is recognized that if program utilization increases substantially as a result of the Experiment, and additional consultants are needed, an active recruitment campaign can be reinstituted.

The decision was made then to work with the physicians presently enrolled on the Panel, and invite them to extend their Second Surgical Opinion services to Medicare Beneficiaries.

The physician population was decreased from 2000 to 1373, as New Jersey, Connecticut and Queens surgeons were eliminated as potential consultants under the Experiment (the Contractor does not serve as Medicare Carrier in these two states and the county of Queens).

However, as will be discussed later, a program modification was instituted to include Queens residents seeking second opinion services from Queens surgeons; this increased the final Panel membership to 1503.

Methodology For Extending Second Surgical Opinion Services To Medicare Part B Beneficiaries

During the last week of March 1978, letters of invitation were mailed to these surgeons presently enrolled on the Blue Cross and Blue Shield of Greater New York Panel. As is evident, two different communications were necessary; one to those Providers we service under Medicare, and a second to Queens Providers with whom the Contractor, as a Medicare Carrier, does not usually interact.

A negative listing has been planned in that only physicians who do not wish to service Medicare eligible Beneficiaries in this Experiment have been requested to respond.

At the time of the writing of this protocol approximately 10 responses had been received; two physicians were no longer in practice, one felt the reimbursement was inadequate, and the others did not state why they chose not to service Medicare Beneficiaries in the Experiment. Despite the instructions, some forms may inadvertently be returned by surgeons who wished to participate in the Experiment. Therefore, every fourth form, received without an accompanying reason, will generate a phone call for verification.

It is to be noted that any qualified surgeon may enroll on the Panel at any time simply by completing an agreement card and abiding by the terms of the signed agreement.

Approximately 100 surgeons have initiated their own enrollment by calling or writing the Center for these cards. Physicians in this category are frequently recently certified, new residents of the Blue Cross and Blue Shield of Greater New York service area, and/or have of late become interested in the Second Opinion concept.

Enrollment through this self initiated modality will continue. New candidates for enrollment will, in addition to the basic Program description, agreement card and agreement, be mailed a letter describing the Medicare Experiment. For new Panel members, willingness to service the Medicare Beneficiary, as well as the BCBSGNY subscriber, is anticipated and expected.

We have met with and explained the Experiment to the Professional Representative staff of BCBSGNY. These individuals deal directly with the physician population on a daily basis and have each been given a supply of the above. They will, in their contacts with surgeons, work to enlist their enrollment.

Maintaining Program Integrity

Every effort has and will continue to be made to protect the terms of the Cooperating Physician's Agreement.

Extenuating circumstances, however, do occur that warrant review but may not necessitate Panel resignation. They will be handled as follows:

° Any physician engaging in activities which contradict the contents of the signed agreement will be addressed personally in writing.

° The physician's response and explanation will be individually evaluated by the Programs Administrative and Professional Staff; dismissals will be implemented as warranted.

DISTRIBUTION OF PANEL PARTICIPANTS

PRESSO COOPERATING PHYSICIANS						BLUE CROSS AND BLUE SHIELD OF GREATER NEW YORK				
Specialty	BKLYN	BRONX	CONN	LONG ISLAND	NEW JERSEY	NEW YORK	QUEENS	STATEN ISLAND	UPSTATE	TOTAL
COLON AND RECTAL	1			3		7	2		1	14
GENERAL *	59	25	21	88	93	116	25	8	64	499
NEUROLOGICAL	1			1	7	7			6	22
ORAL	24	12	35	49	42	30	24	6	16	238
ORTHOPEDIC	14	5	10	42	37	36	6	1	14	165
OBSTETRICS & GYNECOLOGY	70	24	21	79	107	121	48	6	18	494
OPTHALMOLOGY	23	10	16	38	46	61	8	2	14	218
OTOLARYNGOLOGY	15	4	9	17	23	34	5	2	9	118
PEDIATRIC	6			6	2	7			1	22
PLASTIC	4	2	3	9	6	11			3	38
PODIATRY	4	1		6		4	1		2	18
THORACIC	8	9	4	17	11	14	5		4	72
UROLOGY	14	6	9	15	14	24	6	1	12	101
TOTAL	243	98	128	370	388	472	130	26	164	2019

* Includes -- Breast, G.I., Hand, Head and Neck, Abdominal and Vascular.

** CONNECTICUT and NEW JERSEY: these surgeons are not involved in the Medicare Part B Experiment, since the Contractor is not the Medicare Carrier in these states.

Updated - March, 1978.

Blue Cross
Blue Shield
of Greater New York

P.O. Box 551, Murray Hill Station
New York, New York 10016

PRESSO

AGREEMENT BETWEEN BLUE CROSS AND BLUE SHIELD OF GREATER NEW YORK

(hereinafter referred to as the Plan)

AND

COOPERATING PHYSICIANS

Any Cooperating Physician, who accepts a covered member for a second or third opinion under this Program, agrees not to perform the surgery or otherwise treat the Covered Member for the specific condition which resulted in the request for this second or third opinion and to render services available under this Program in accordance with its terms and conditions. Furthermore, the Cooperating Physician agrees not to refer the accepted Covered Member to a colleague with whom he or she is financially associated. The physician further agrees that payment in the amount of $50.00 shall constitute payment in full for the second or third opinion inclusive of follow-up visits and no charge shall be made to the Covered Member. No practitioner shall be compelled to accept a Covered Member as a patient and nothing in the Plan's contract is intended to alter or change the normal relationship of physician and patient.

This agreement may be terminated at the option of either the Plan or the Cooperating Physician by giving at least 30 days prior written notice to the other.

To join as a Cooperating Physician in this Program you have only to complete the enclosed card and return it to Blue Cross and Blue Shield of Greater New York.

Sterling E. Cathey

STERLING E. CATHEY
SECRETARY

Edwin R. Werner

EDWIN R. WERNER
PRESIDENT

LGL 397

Blue Cross
Blue Shield
of Greater New York

PRESSO

SECOND OPINION REFERRAL CENTER
P.O. Box 551, Murray Hill Station
New York, New York 10016

I HEREBY AGREE TO RENDER A SECOND OR THIRD OPINION UNDER THE PROGRAM FOR ELECTIVE SURGICAL SECOND OPINION IN ACCORDANCE WITH THE TERMS SET FORTH IN THE COOPERATING PHYSICIANS AGREEMENT AND IN THE PROGRAM DESCRIPTION DATED SEPTEMBER 1975 TO SUCH COVERED MEMBERS OF THE PLAN AS I ACCEPT.

PRINT NAME (LAST FIRST)	SIGNATURE	DATE SIGNED

OFFICE ADDRESS(ES) (STREET NO., CITY, STATE, ZIP CODE)	
	TELEPHONE NUMBER

SPECIALTY YES ☐ NO ☐	IF YES, NAME OF SPECIALTY BOARD	DATE OF CERTIFICATION
SUB-SPECIALTY YES ☐ NO ☐	IF YES, NAME OF SUB-SPECIALTY BOARD	DATE OF CERTIFICATION

HOSPITAL AFFILIATION(S)	
1.	4.
2.	5.
3.	6.

LGL 399
(10-76)

Blue Cross
Blue Shield
of Greater New York

PRESSO

LETTERS SENT TO PANEL SURGEONS PRACTICING IN THE 16 COUNTY AREA THAT THE CONTRACTOR SERVES AS MEDICARE CARRIER

March, 1978

Dear Doctor:

Last Fall, Blue Cross and Blue Shield of Greater New York (BCBSGNY) was awarded a contract by the Health Care Financing Administration, Department of Health, Education, and Welfare, to conduct a second surgical opinion demonstration project for Medicare Part B beneficiaries over a three year period: May 1978 to May 1981. This has increased the number of individuals eligible for a free surgical second opinion in the Greater New York area by approximately 1.2 million.

The purpose of this demonstration is to help HEW to determine whether second opinion programs improve the quality of health care, as well as help to contain its costs. The primary difference between this demonstration and the national approach to second opinions being designed by HEW, is that beneficiaries covered under the demonstration have no coinsurance or deductible liability.

I am writing to request that you extend second opinion services you previously agreed to provide to BCBSGNY subscribers under the PRESSO program to eligible Medicare beneficiaries.

All key aspects of the Program in which you previously elected to participate for BCBSGNY subscribers apply to Medicare beneficiaries and include the following:

1. The second or third opinion of a surgical specialist as well as the laboratory and x-ray procedures necessary for such an opinion will be provided without cost to the beneficiary.

2. Reimbursement, under assignment, of up to $50.00 will be paid by Blue Cross and Blue Shield of Greater New York directly to a surgical specialist based on the specialist's agreement to accept the fee as payment in full. A detailed description will appear on the consultant's Medicare summary check.

The mechanics of the Program will remain essentially the same. However, patients will present to you a yellow stock SSA 1490 identified as an "Experimental Second Opinion Claim", instead of the BCBSGNY billing form. Beneficiaries with this form do not have to meet coinsurance and deductible requirements.

In addition to the benefit being available to all eligible beneficiaries whose first surgeon's recommendation was for surgery, it will also be provided to individuals whose first surgeon recommended against surgery.

Regardless of whether the surgical specialist's recommendation is different from or the same as the first surgeon, if requested by the beneficiary, a third opinion by another surgical specialist will be provided under the same conditions as outlined above.

Similarly, as with the BCBSGNY program, compliance with the following terms is expected:

1. Agreement not to perform surgery or otherwise treat the patient for the specific condition involved, nor refer the patient for treatment to any other physician with whom he/she is financially associated.

2. Agreement not to perform the following endoscopic examinations: bronchoscopy, colonoscopy, culdoscopy, cystoscopy, or peritoneoscopy. If the surgical specialist is unable to render an opinion without such an examination, he or she is requested to indicate this when making recommendations.

3. Agreement to maintain appropriate records and provide timely reports of findings and recommendations to Blue Cross and Blue Shield of Greater New York.

We hope that you will assist us in this endeavor.

If you have any questions regarding this Program, may I suggest you call the Project Director of the experiment, Patricia O'Connor at (212) 481-2657.

Should you elect not to extend your Cooperating Physician services to eligible Medicare Beneficiaries, kindly complete the enclosed forms and return in the pre-addressed envelope by April 15th.

If we do not hear from you to the contrary, we will refer Medicare Beneficiaries to you after May 1, 1978.

Sincerely,

Ruth Haase

Ruth Haase
Assistant Vice President

RH:kag

BLUE CROSS AND BLUE SHIELD
OF GREATER NEW YORK

MEDICARE PART B SURGICAL SECOND
OPINION EXPERIMENTAL PROGRAM

PLEASE, DO NOT RETURN THIS FORM UNLESS YOU DO NOT WISH TO HAVE ELIGIBLE MEDICARE BENEFICIARIES REFERRED TO YOU FOR SECOND SURGICAL OPINIONS

I HEREBY DO NOT AGREE TO RENDER A SECOND OR THIRD OPINION TO BENEFICIARIES UNDER THE MEDICARE PART B EXPERIMENTAL PROGRAM FOR SURGICAL SECOND OPINIONS, IN ACCORDANCE WITH THE TERMS SET FORTH IN THE COOPERATING PHYSICIANS AGREEMENT WHICH I PREVIOUSLY SIGNED FOR COVERED MEMBERS OF BLUE CROSS AND BLUE SHIELD OF GREATER NEW YORK.

PRINT NAME PLEASE_____ SIGNATURE _____

OFFICE ADDRESS _____

REASON (IF DESIRE TO IDENTIFY) _____

IF APPLICABLE,
PLEASE RETURN BY APRIL 15, 1978

SHOULD YOU ELECT TO PROVIDE THESE SERVICES, AND A BENEFICIARY PRESENTS IN YOUR OFFICE FOR A CONSULTATION WITHOUT AN EXPERIMENTAL CLAIM FORM, HE/SHE MAY BE ELIGIBLE FOR THE NO COST BENEFIT.

IF YOU WOULD ADVISE THEM TO CALL THE REFERRAL CENTER (481-2658), WE WILL ESTABLISH THEIR ELIGIBILITY AND NOTIFY YOU.

WE WOULD REQUEST IN THESE INSTANCES, THAT YOU DO NOT BILL FOR THE SERVICE UNTIL YOU HEAR FROM US.

THANK YOU

Blue Cross
Blue Shield
of Greater New York

PRESSO

LETTERS SENT TO PANEL SURGEONS PRACTICING IN QUEENS COUNTY WHERE THE CONTRACTOR DOES NOT SERVE AS MEDICARE CARRIER

Dear Doctor:

Last Fall, Blue Cross and Blue Shield of Greater New York (BCBSGNY) was awarded a contract by the Health Care Financing Administration, Department of Health, Education, and Welfare, to conduct a second surgical opinion demonstration project for Medicare Part B beneficiaries over a three year period: May, 1978 to May, 1981.

The purpose of this demonstration is to help HEW to determine whether second opinion programs improve the quality of health care, as well as help to contain its costs. The primary difference between this demonstration and the national approach to second opinions being designed by HEW is that beneficiaries covered under the demonstration have no coinsurance and deductible liability.

As you know, BCBSGNY is not the Part B Carrier in Queens County and, therefore, under ordinary circumstances, would not be in contact with you regarding Medicare beneficiaries. However, in the interest of providing access to this cost-free benefit to as many Medicare beneficiaries as possible, the Medicare Bureau and Group Health Incorporated (GHI) have agreed to afford us the opportunity to invite you to extend second surgical opinions (which you have agreed to provide to BCBSGNY subscribers) to eligible Medicare beneficiaries referred through the BCBSGNY Second Opinion Center.

Should you elect to provide these services, reimbursement under assignment of up to $50 for consultation will be through BCBSGNY for Medicare experimental second opinion services only. GHI will continue to serve as your Medicare Carrier for all services other than those rendered under the Medicare Second Surgical Opinion Experiment.

All key aspects of the Program in which you previously elected to participate for BCBSGNY subscribers apply to Medicare beneficiaries and include the following:

1. The second or third opinion of a surgical specialist as well as the laboratory and X-ray procedures they might perform will be provided without cost to the beneficiary.

2. Reimbursement under assignment of up to $50 will be paid by Blue Cross and Blue Shield of Greater New York directly to a surgical specialist based on the specialist's agreement to accept the fee as payment in full.

The mechanics of the program will remain essentially the same. However, patients will present to you a yellow stock SSA 1490, identified as an "Experimental Second Opinion Claim", instead of the BCBSGNY billing form. Beneficiaries with this form do not have to meet coinsurance and deductible requirements.

In addition to the benefit being available to all eligible beneficiaries whose first surgeon's recommendation was for surgery, it will also be provided to individuals whose first surgeon recommended against surgery.

Regardless of whether the surgical specialist's recommendation is different from, or the same as the first surgeon, if requested by the beneficiary, a third opinion by another surgical specialist will be provided under the same conditions as outlined above.

Similarly, as with the BCBSGNY program, compliance with the following terms is expected:

1. Agreement not to perform surgery or otherwise treat the patient for the specific condition involved, nor refer the patient for treatment to any other physician with whom he/she is financially associated.

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Should you elect not to extend your Cooperating Physician services to eligible Medicare Beneficiaries, kindly complete the enclosed form and return in the pre-addressed envelope by April 15th.

If we do not hear from you to the contrary, we will refer Medicare recipients to you after May 1, 1978.

Sincerely,

Ruth Haase

Ruth Haase
Assistant Vice President

BLUE CROSS AND BLUE SHIELD
OF GREATER NEW YORK

MEDICARE PART B SURGICAL SECOI
OPINION EXPERIMENTAL PROGRAM

PLEASE, DO NOT RETURN THIS FORM UNLESS YOU DO NOT WISH TO HAVE ELIGIBLE MEDICARE BENEFICIARIES REFERRED TO YOU FOR SECOND SURGICAL OPINIONS

I HEREBY DO NOT AGREE TO RENDER A SECOND OR THIRD OPINION TO BENEFICIARIES UNDER THE MEDICARE PART B EXPERIMENTAL PROGRAM FOR SURGICAL SECOND OPINIONS IN ACCORDANCE WITH THE TERMS SET FORTH IN THE COOPERATING PHYSICIANS AGREEMENT WHICH I PREVIOUSLY SIGNED FOR COVERED MEMBERS OF BLUE CROSS AND BLUE SHIELD OF GREATER NEW YORK.

PRINT NAME PLEASE_____ SIGNATURE_____

OFFICE ADDRRES_____

REASON (IF DESIRE TO IDENTIFY)_____

IF APPLICABLE,
PLEASE RETURN BY APRIL 15, 1978

SHOULD YOU ELECT TO PROVIDE THESE SERVICES, AND A BENEFICIARY PRESENTS IN YOUR OFFICE FOR A CONSULTATION WITHOUT AN EXPERIMENTAL CLAIM FORM, HE/SHE MAY BE ELIGIBLE FOR THE NO COST BENEFIT.

IF YOU WOULD ADVISE THEM TO CALL THE REFERRAL CENTER (481-2658), WE WILL ESTABLISH THEIR ELIGIBILITY AND NOTIFY YOU.

WE WOULD REQUEST IN THESE INSTANCES, THAT YOU DO NOT BILL FOR THE SERVICE UNTIL YOU HEAR FROM US.

THANK YOU

EMPLOYEE EDUCATION

In an effort to reduce confusion between this Experiment and the "Routine" Second Opinion Benefit offered under Medicare, the following tool has been devised. We believe it will be of assistance to staff members working in Beneficiary Service Areas, who must be informed of the distinguishing characteristics of both covered services.

Additionally, it will be distributed among administrative personnel who are, or will be, involved with implementing either benefit.

REFERENCE TABLE
MEDICARE PART B - SECOND SURGICAL OPINION BENEFIT

A COMPARISON BETWEEN THE "EXPERIMENTAL PROGRAM" AND THE "ROUTINE" COVERED SERVICE

MARCH, 1978

DEVELOPED BY:

- MEDICARE COORDINATION AND ADMINISTRATIVE SERVICES
- PROGRAM FOR ELECTIVE SURGICAL SECOND OPINION

BLUE CROSS & BLUE SHIELD OF GREATER NEW YORK

- GUIDELINES -

SECOND OPINIONS FOR ELECTIVE SURGERY

Blue Cross and Blue Shield of Greater New York will be administering an experimental program on Second Surgical Opinions for Elective Surgery over a three year period (May 1978 to May 1981). At the same time, all Carriers (including BCBSGNY) will be implementing a program to identify and reimburse second opinions as a regular covered service under Medicare Part B.

Major differences exist between these two benefits. The attached reference table outlines these variances.

This experimental project is not to be confused with the Part B Intermediary Letter 77-40 which also addresses second opinions on surgery. It should be noted that definitive guidelines for interpretation of the IL have not yet been released.

In the interim, we are assuming they will take the direction outlined in the following table. At present, the Department of Health, Education, and Welfare is aware of its content and agrees that it represents the currently envisioned framework of the National Program. These guidelines are designed for BCBSGNY internal use only. Should there be any program changes, the program will be modified accordingly.

Briefly, the most significant aspects of the Experimental Program, in contrast to the design of the National Program are:

1. Eligible beneficiaries will have no financial responsibilities for second or subsequent surgical consultations (coinsurance and deductible are waived).

2. Benefits will only be extended if the beneficiary calls the Second Opinion Referral Center (481-2658) prior to seeking a second opinion.

3. Eligible beneficiaries must see one of the 1300 board certified surgeons who are enrolled on the Second Opinion Panel.

4. Eligible beneficiaries who request to see Panel member surgeons in Queens County may do so. Reimbursement will be through the Medicare Carrier, BCBSGNY. Group Health Incorporated will continue to serve as the Medicare Carrier for all services other than those rendered under the experiment.

REFERENCE TABLE:

	EXPERIMENTAL PROGRAM	REGULAR COVERED SERVICE
ELIGIBILITY	Beneficiary: ° Must be eligible for Part B Medicare ° Must reside in, and obtain consultation service from Panel Providers in one of the 16 counties we serve as Carrier. (Queens residents serviced by Queens Providers are also eligible). ° Must have seen a surgeon regarding elective surgery (surgery does not have to be recommended). ° Must make arrangements for a Second Opinion through the Referral Center at BCBSGNY 481-2658, prior to seeing a Second Opinion Surgeon. NOTE: If a beneficiary calls the center with a pre-selected surgeon, he may be eligible for the Experiment provided that the surgeon is on the panel and the patient has not yet had the consultation.	Beneficiary: ° Must be eligible for Part B Medicare. ° Can seek consultation from Providers anywhere, and bill appropriate Carrier. ° Must have visited a qualified physician who discussed or recommended surgery. (No time limit ... Primary physician need not be a surgeon.) ° Has same access to benefit as with all Provider Services. No special arrangements needed.
MECHANISM	Beneficiary: ° Calls Referral Center. ° Is provided with names of 3 Board Certified surgeons, who are, whenever possible, conveniently located to their home and in the same specialty as their primary surgeon. ° Selects a surgeon and arranges an appointment (if so desired, center will arrange appointment) ° Is sent specially designed SSA 1490's after appointment is scheduled.	Beneficiary: ° May call DHEW Hot Line, SSA-DO, or Local Welfare Office to obtain name of list holder who will provide the name of a physician(s) who has agreed to render consultant services. ° May use any of the qualified physicians that he chooses. ° Arranges own appointment. ° Completes routine 1490.

REFERENCE TABLE:

	EXPERIMENTAL PROGRAM	REGULAR COVERED SERVICE
REIMBURSEMENT	° 100% up to $50 for assigned consultation charges. ° 100% for Lab/X-rays ordered by consultant. ° COINSURANCE & DEDUCTIBLE WAIVED.	° Routine reimbursement: 80% of approved charges after deductible is met.
	Available on request using same method outlined previously (regardless of whether or not second opinion differs from first).	Available only if second opinion differs from first (See IL 77-40), although IL 78-9 clarified this matter by stating: "Because of the difficult development associated with determining each physician's recommended course of treatment, carriers will assume that where a third opinion is sought by the beneficiary, the first two opinions differed."
DURATION	Experiment runs for 3 years; May 1978 - April 1981	Continuous as a regular covered service beginning March 1978.

REFERENCE TABLE:

	EXPERIMENTAL PROGRAM	REGULAR COVERED SERVICE
Utilization Review	No system check. Bypassing current U.R. screens.	Special U.R. system checks.
Quality Assurance System	Excluded, pending reassessment in 6 months.	Routinely included.
History File	Special Payment Tape Files	Routine History entries.
Region Code	Recommendation under consideration for special code.	None required.
Payment	To physician, beneficiary and/or lab.	Same.
EOMB	Check notation and special message stating "Second Opinion".	Same.
Service Identification	It is anticipated that the service will be identified by "type of service" codes M through X, ie: M9055.	Services will be identified by "type of service" codes Y and Z, ie: Y9055.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
HEALTH CARE FINANCING ADMINISTRATION
BALTIMORE, MARYLAND 21235

REFER TO:
IHI-314

NOVEMBER 1977

PART B INTERMEDIARY LETTER NO. 77-40

SUBJECT: Second Opinions on Surgery

On November 1, 1977, Under Secretary Hale Champion outlined in testimony before the Subcommittee on Oversight and Investigations, House Committee on Interstate and Foreign Commerce, a series of steps to deal with the problem of unnecessary surgery. Among other things, he announced that HEW is going to "begin a major effort to encourage the American public, and especially our own beneficiaries, to seek second physician opinions," when surgery is being considered. The Under Secretary stated that this new effort will be monitored carefully and promised to report to the Congress on its progress within 6 months.

Although many details remain to be worked out, it is clear that carriers will play an important role in the implementation of this major effort to deal with unneeded surgery. The purpose of this intermediary letter is to make carriers aware of this effort and to provide interim instructions on their role in carrying it out.

Second opinions are "physicians' services" within the meaning of section 1861(q) of the law and implementing regulations. There has been no specific policy instruction concerning their coverage issued in the past nor any concerted effort until now to employ this mechanism under Medicare as a means to reduce unnecessary surgery. The current effort will emphasize that second physician opinions pertaining to potential surgeries are not only covered but are recommended and encouraged.

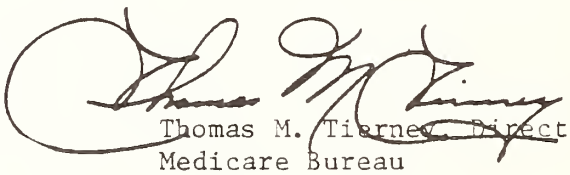
Therefore, carriers are to pay for claims for patient-initiated second physician opinions pertaining to the medical need for surgery. Payment may be made for the history and examination of the patient as well as any other covered diagnostic services required in order for the physician to properly evaluate the patient's condition and render a professional opinion on the medical need for surgery. In the event that the recommendations of the first and second physician differ regarding the medical need for such surgery, a claim for a patient-initiated physician opinion from a third physician is also reimbursable. Such claims are payable

even though the beneficiary has the surgery performed against the recommendation of the second (or third) physician. (Consultations furnished at the request of the attending physician continue to be covered in accordance with section 2020D of the Medicare Carriers Manual.)

Part B payments for patient-initiated second (or third) opinions will be based on the reasonable charges carriers ordinarily allow for consultations and related services. Charge data derived from claims for second (or third) opinions should be merged with the data for consultations and related services for the purpose of subsequent updatings of carrier customary and prevailing charge screens. Beneficiaries are, of course, responsible for applicable deductible and coinsurance amounts.

As noted above, this new effort will be monitored carefully by HEW. As an interim measure, carriers should: (1) use their professional relations issuances; etc., to instruct physicians to identify second and third opinions as such on their bills and claims forms, and (2) devise and use special codes consistent with their existing procedural terminology and coding systems to specifically record and retain for retrieval from their computer records data related to second and third opinions. A major objective of the monitoring will be to determine the effect of second and third physician opinions on the incidence of surgery utilization and the cost experience of this effort. Carriers must take action to uniquely identify and differentiate between second and third opinions upon data input. This identifier will be carried through the claims process, including identification in the beneficiary's claims history, to preparation of payment records. For payment record purposes, second opinions will be identified by Type of Service Code Y and third opinions identified by Type of Service Code Z. These unique identifiers must be entered with all claims processed on or after March 1, 1978, but we would appreciate it being done sooner, if possible.

Additional and more detailed instructions are being developed. We would like to have the carriers' ideas and suggestions about how this project should be implemented beyond these interim instructions. Please direct your comments to the Division of Provider and Medical Services Policy, Medicare Bureau, Room 189, East Building, 6401 Security Boulevard, Baltimore, Maryland 21235. Another major aspect of this effort will be to publicize the availability of second physician opinions on potential surgery to Medicare beneficiaries. Various publicity mechanisms are now being considered.



Thomas M. Tierney, Director
Medicare Bureau

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
HEALTH CARE FINANCING ADMINISTRATION
BALTIMORE, MARYLAND 21235

REFER TO:
IHI-432

March 1978

PART B INTERMEDIARY LETTER NO. 78-9

SUBJECT: Clarification of Systems Instructions in IL 77-40 Relating to Second Opinions on Surgery

We have received several questions about IL 77-40 which indicate that clarification regarding the systems procedure is needed. The following should resolve some of these issues.

1. Will all payment records which include a second/third opinion require the "Y" or "Z" type of service code, regardless of whether the "opinion" service is the largest charge item on the claims? i.e., is there a change to current payment record procedures?

   The intent of IL 77-40 is that all "opinion" services be reported with the "Y" or "Z" code regardless of whether it is the largest charge item on the payment record. To accomplish this it would require a change in payment record procedures. In order to permit the reporting of "opinion" services without having to change existing payment record logic, carriers will split claims involving "opinion" services; i.e., all opinion services should be processed as one claim, all other services as a second claim. Therefore, the following definition should be added to the "split" claims list described in Medicare Carriers Manual §3000.1, "A claim that contains both services which can be identified as second/third opinion services and services not related to the second/third opinion should be split into two separate claims. One claim is to contain the 'opinion' services, the other the 'nonopinion' services."

2. How will reasonable charge pricing for second opinions be handled?

   Carriers are not being asked to change their reasonable charge methodology to accommodate the coverage of second

opinions. All we ask is that they annotate the payment records with Y and Z codes for second and third opinion services. The coding and pricing of second and third opinion services will use existing pricing methodology and profiles.

The Model System is using "Special Payment Indicators" to generate the two new types of service codes for the payment record. The codes used will not interfere with processing. They will be carried through the system and converted to type of service code Y or Z when the payment record is created.

The following example has been copied from the Model System Input Module Documentation to show how the special payment indicators will be used for radiology/ pathology services:

G. Diagnostic Lab Tests (Negotiated Fees)

- Code a 7 in this field if:

    1. The charges submitted are for a diagnostic lab service involving negotiated fees furnished directly by an independent laboratory and to be paid at 100 percent reimbursement; and

    2. The charges allowed are to be coded; and

    3. Services are on or after October 30, 1972.

- Code a K in this field if conditions 1, 2, 3 apply and this is for second opinion on surgery.

- Code an L in this field if conditions 1, 2, 3 apply and this is for third opinion on surgery.

NOTE: Type of Service (position 35) must contain a code 5 (Diagnostic Laboratory) if indicator is 7, K, or L.

Place of Service (position 32) must contain a code 6 (Independent Laboratory) if indicator is 7, K, or L.

We have provided this logic only as a suggestion for your consideration. Your own system staff may have other methods to effectively produce the "Y" and "Z" type service codes for payment record purposes.

3. Will carriers be required to maintain special records on second or third opinion claims?

Carriers are not being asked to maintain special cross-referenced records for second or third opinions. HCFA anticipates conducting a limited study on the use of second and third opinions; we will use the claims that are identified through the Y and Z payment record codes. In the course of conducting a study, it is probable that HCFA will contact carriers for history data relative to the specific claims that have been identified. The information requested will only be that which is available in the carriers' files from their current claims processing operations. The carriers are not being asked, at this time, to carry any additional information over and above that which they currently maintain. In IL 77-40, we asked that carriers take action to uniquely identify and differentiate "opinion" data on input. The carriers' regular records and the "Y" and "Z" identification methodology will provide sufficient capability for subsequent monitoring of "opinion" services.

4. Is the "opinion" program limited to board-certified surgeons?

The second/third opinion instructions in IL 77-40 pertain to the services performed by any physician, including tests done in conjunction with the opinion to determine the need for surgery. It may be difficult in some cases to determine if the opinion service was related to the question of the need for surgery. It will not be necessary to develop these claims but they should be coded. Therefore, all "opinion" services, whether related directly to surgery or not, should be identified and reported with the "Y" or "Z" code.

5. Is the March 1, 1978, Implementation date specified in IL 77-40 a firm date?

Yes. As of March 1, 1978, carriers must begin to identify claims involving "opinions" services. As these claims are so identified, they must be reported to the Medicare Bureau with "Y" or "Z" type of service codes on the payment records.

6. Will special forms be required?

Unless a carrier is participating in one of the demonstration projects on second opinion already being conducted or to be conducted, there will be no change in the claims form. The carriers involved in these demonstration projects will be given separate and complete procedures.

7. Are third opinions covered only in the event that the first and second opinions disagree?

In IL 77-40, we stated: "In the event that the recommendations of the first and second physician differ regarding the medical need for such surgery, a claim for a patient-initiated physician opinion from a third physician is also reimbursable." Because of the difficult development associated with determining each physician's recommended course of treatment, carriers will assume that where a third opinion is sought by the beneficiary, the first two opinions differed. Therefore, in the absence of evidence in the file to the contrary, all claims for third opinions services are covered and should be processed so that the payment record shows type service code "Z."

Policy questions pertaining to the structure of the Department's second opinion program, the public informational compaign and certain other operational matters are under active consideration at this time by the Department. As soon as decisions are made on these questions, we shall inform you of them and issue instructions that pertain to any responsibilities carriers may have for implementing these decisions.

Thomas M. Tierney, Director
Medicare Bureau

BENEFICIARY EDUCATION

A significant level of utilization is probably one of the most important components contributing to the success of this Experiment. Unless the Medicare population is oriented to the availability of the benefit, the Program will not be utilized significantly.

The problems that must be met in making this program effective include:

° Informing beneficiaries that the benefit is available.

° Stimulating utilization of the benefit whenever elective surgery is considered.

° Publicizing the benefit while defining clearly that eligibility is contingent upon geographic location, and pre-registration with the Referral Center.

° Differentiating the Experiment from the "Routine" Second Opinion benefit.

The fact that many older persons are not receptive to changes in established patterns makes it necessary that these efforts be continuous and repetitive. Since grown children or other relatives are frequently involved in the decision making regarding elective surgery for Medicare beneficiaries, publicity activities cannot be limited solely to beneficiaries, but must encompass the entire community.

Additionally, it is imperative that this new benefit be publicized in settings where Medicare eligible persons are active, or are residing. These would include community groups, homes for the aging, and nursing homes.

One of our major educational activities to contribute to Program Utilization has been undertaken by the Coordinator of Community Affairs, Lois Neufeld. A description of her "Outreach Approach" is as follows:

° When the Outreach campaign was first planned for this Experiment, what was considered to be an "ideal" plan was designed. It was a comprehensive approach which took into consideration the fact that changing attitudes and behavior is a slow process which necessitates reinforcement on many levels.

° Of all the methods tried and tested throughout the years attempting to change behavioral patterns, the group-setting approach has had the greatest overall success. People with common problems are grouped together for lecture and discussion and are expected to provide each other with the support and encouragement necessary for change.

- The Coordinator looked at the outreach task before her with the group-setting approach in mind. If a meaningful change in the way the elderly interface with the health care system was to be effectuated, the educational effort would have to begin in the 1200 plus Senior Citizen Centers which fall within our Experimental area. The effort was designed to begin in the Centers and hopefully be reinforced by doctors, public service announcements, print advertising and the distribution of a host of materials.

- In addition, the plan called for the development of an educational handbook which would act as a reference guide and point of departure for discussions in the Centers. Since most Senior Centers have at least one professional on staff, this individual would be responsible for leading the discussion.

Working with the National Council on the Aging, an organization which has spearheaded many innovative programs in the area of the aging, a dummy 8 page handbook was developed. When the cost of writing, developing and printing 3,500 to 5,000 handbooks was researched, it was discovered to exceed $10,000. Subsequently a decision was made to eliminate this approach.

We anticipate accomplishing the same end, Beneficiary awareness regarding Second Surgical Opinions, by employing the less costly method outlined below.

Objectives (Outreach Program)

- To inform and educate the greatest possible number of Medicare Part B Beneficiaries regarding the Medicare Second Surgical Opinion Experiment.

- To effectuate behavioral change when possible, so that the concept of a second surgical opinion becomes ingrained rather than the exception.

Methodology (Outreach)

- Inasmuch as we are dealing with a target population of approximately 1.5 million eligible Beneficiaries in a 17 county area, it has become incumbent upon the coordinator to establish a network of contacts throughout the area to assist in the dissemination of information and formulation of educational programs. Towards this end the following communications network is now in place:

  - The 17 county departments on the aging have been informed about the Medicare Second Opinion program and have offered to

    - distribute thousands of informational brochures and posters to nutrition and Senior Citizens sites,

Methodology: (continued)

- ° run articles in their county newsletters publicizing the Experimental Program,
- ° present a description of the Program and how to make use of this benefit on their half hour radio programs devoted to the problems of the aging,
- ° provide their local radio stations with a public service spot announcing the new benefit.
- ° inform us of upcoming health fairs in their county so that we might take advantage whenever possible of a natural outlet for reaching large numbers of Senior Citizens. For example, in May, the Westchester County Department on the Aging will be sponsoring a "Salute to Senior Citizens". According to the department, some 5,000 to 6,000 Senior Citizens usually attend. The Community Affairs Coordinator has already reserved a booth and will be present to distribute informational brochures and speak with individual Senior Citizens about the Experimental Program,
- ° maintain on-going communication during the three year Experiment in order to jointly develop new outlets for publicizing the benefit and new ideas for educating the Senior Citizens.

° The largest voluntary organizations headquartered in New York City dealing with the aging have been contacted and informed of the program. They have offered to run front-page articles in their newsletters and to distribute brochures and posters whenever and wherever possible.

° Blue Cross and Blue Shield of Greater New York will try to make use of their public service announcement for reaching the radio listening audience. Introductory letters and a 30 second radio spot will be sent to approximately 35 stations in New York and Long Island and another 15 plus will be distributed by the county departments on the aging to their local stations with whom they are in close communication.

° The Community Affairs Coordinator has arranged to supervise the dissemination of press releases, informational materials and brochures to her established network and ensure that the communications needs of all agencies and organizations are met. Additionally,

- ° inasmuch as there are approximately 2,000 Senior Citizen Centers in the 17 county area, the Coordinator will attempt to identify the larger ones and make spot visits whenever possible after the May 22 implementation date.

Methodology: (continued)

° We are cognizant of the importance of disseminating accurate information, particularly in writing, which will probably be the Beneficiary's primary source of facts regarding the Experiment. Ideally then, all articles printed by local agencies for circulation in Senior Citizen pamphlets, magazines, etc., should be reviewed by the Contractor prior to its release. However, if this restriction were placed on the agencies, we are concerned that this could discourage the publicity campaign we are anticipating. Though every effort will be made to prevent erroneous information from being printed in local newsletters, it is therefore unrealistic to assume that we can completely prevent its occurrence when we are dealing with such a large population over a relatively extensive geographic area.

Needs of the elderly as relates to health education:

° Discussions have been held with leaders in the areas of health education and the aging who contend that any effective campaign geared to changing people's attitudes must have a multi-level approach built into it. This includes comprehensive educational strategies, strict monitoring mechanisms, in addition to reinforcement tools such as brochures and posters.

Accomplishments Of Outreach Activities

° At the present time, the major organizations and agencies involved in servicing the needs of the Medicare population have all been apprised of our Second Opinion Program and their response to the program has been overwhelmingly positive. The Coordinator has received excellent cooperation from all the agencies and is receiving the support and assistance necessary to effectively publicize the benefit to the 65 and over population. In addition, good working relationships have been established with the Executive Directors of the County Departments On The Aging, and their attention and assistance can be easily gained when necessary.

Number of Individuals Outreach Program Will Touch: Initially and Projectedly

° Based on the number of brochures which will be distributed in the 17 Counties, articles which will run in county and agency newsletters and a 30 second Public Service Announcement to be broadcast throughout the Counties, it is estimated that 400,000 individuals will be notified of the Program initially. With additional publicity through health fairs and the continuous distribution of informational materials and speaking appearances before senior groups, if the resource is available, it is projected that close to 800,000 will be made aware of the Program through outreach efforts alone in the 3 year period.

The Mechanism To Be Devised In Order To Collect Data On Community Activities

° Given the limitations of staff and resources, any data on community activities will be collected in a loose, non-scientific fashion. Periodically, 17 County Departments on the Aging will be requested to provide information on what activities have been implemented.

The Community's Response To The Outreach Activities

° There is no way to judge prior to the publicizing of this Program, what the community's response will be. There may well be a very real interest generated initially by the promotional brochures and public service announcements, and yet interest could wane soon thereafter. It is for this reason that the coordinator will stay in close communication with the county departments on the aging. It will be her responsibility to see that the on-going needs for additional information are met.

AGENCIES AND ORGANIZATIONS CONTACTED TO DATE

17 County Departments on the Aging

F.R.I.A. Friends and Relatives of the Institutionalized Aged

American Association of Retired Persons

New York Statewide Senior Action Council

Aociacion Nacional Pro personas Mayores

National Association of Social Workers

Vacations for the Aging and Senior Centers Association

Community Council of Greater New York

Community Service Society

Selfhelp, Inc.

National Council on the Aging

Hudson-Guild Fulton Senior Center

New York Junior League

Federation of Protestant Welfare Agencies, Inc.

Jewish Association for Services for the Aged

Grey Panthers

Presbyterian Senior Services

Retired Senior Volunteer Program

Salvation Army

New York State Retired Teachers

Coalition of Concerned Older Americans (COCOA)

Advertising

° Advertising is a cost efficient awareness mechanism for communicating messages to the over-65 target audience in the 17 Counties. Print media, specifically newspapers, is the most effective way of reaching this audience. Past experience in product advertising has shown these individuals to be diligent readers of items in which they have a vested interest. Therefore, reader attention will be enhanced by placing "Second Opinion" advertising in sections of newspapers that have high reader traffic for senior citizens, such as Main News and Health/Diet/Food. In addition, only print media can provide the space necessary to cover the many facts inherent in this particular Program.

The Contractor plans an 8 month intensive advertising campaign through the following area newspapers.

PUBLICATION	TOTAL CIRCULATION	INSERTION DATES
'A' List (New York City)		
New York News (C&S)	1,684,400	Tuesdays - 5/16, 5/22, 6/20, 7/11, 8/15, 9/12, 10/17, 11/14, and 12/5.
New York Times	820,200	
New York Post	615,900	
'B' List (Suburban)		
Hudson Valley Network	34,700	Tuesdays - 5/16, 5/22, 6/6, 6/20, 7/11, 8/15, 9/12, 10/17, 11/14, and 12/5.
Westchester Rockland Group	259,000	
Long Island Newsday	476,400	
Middletown Times - Herald Record	60,500	
'C' List (Ethnic)		
Amsterdam News	81,400	Saturdays - 5/20, 5/27, 6/10, 6/24, 7/15, 8/19, 9/16, 10/14, 11/18, and 12/9.
El Diario La Prensa (Daily)	66,700	Tuesdays - 5/16, 5/22, 6/6, 6/20, 7/11, 8/15, 9/12, 10/17, 11/14, and 12/5.
Il Progresso Italo-Americano	75,000	Sundays - 5/21, 5/28, 6/11, 6/25, 7/16, 8/20, 9/17, 10/15, 11/19, and 12/10.
Jewish Daily Forward	46,000	
Staats-Zietung Herold	23,300	

TOTAL CIRCULATION: 4,243,500

Press Release

° In addition to the advertisement, a Press Release will be sent to the Associated Press and United Press approximately one week prior to the Program's start up date. It is hoped that at least one million readers will be reached through this activity.

Marketing/Educational Modalities

° Numerous other Educational/Marketing Activities will be employed. Various approaches have been designed to reach different segments of the population. All, however, are aimed at accomplishing the same end; public awareness and benefit utilization.

Subsequent graphs identify these various modalities, their target population as well as the frequency with which they will be circulated and distributed. In addition, samples of all promotional material will be found at the end of this Section.

Briefly, the approaches include:

° Distribution of brochures/posters to the approximately 50 SSA district offices which service Medicare Beneficiaries in the 17 county area involved in the second opinion experiment.

° Mailing of approximately 500,000 single sheet inserts or "bill stuffers" piggy backed with bills to the Medicare Part B Beneficiaries with Supplemental Medical Insurance through BCBSGNY... This activity is planned for the billing cycle of July through September.

As with all our educational activities, the undertaking of this project will be most appropriately determined by program activity. Since the "bill stuffers" are designed as additional reminders of the benefit, consideration will be given to postponing the onset of this activity if utilization rates are equal to, or exceed projected expectations.

° A special one time mailing of the program's brochure to approximately 600,000 eligible Beneficiaries has been scheduled to begin early June.

However, since the proposed mailing of "bill stuffers" would be essentially notifying the same group of Beneficiaries as this "special mailing", it was decided to select a different population using a tape containing a random sample of the approximately 1.5 million Part B eligible Beneficiaries in the 17 county area.

Subsequently, a tape was developed by HCFA from the Master File Listing, and a program was written by BCBSGNY to generate address cards for this population. The mailing is scheduled to begin in late May.

- Airings of the Public Service Announcement, are anticipated to begin in mid June. The announcement will be mailed to approximately thirty radio stations with whom contact has already been made. It is possible that as many as fifty stations might air the announcement: we would be pleased if thirty-five ran it through the 17 counties. Spots air two times daily (a.m. and p.m.) for approximately a three month period. Some time at the end of September we will implore the stations to continue running the Public Service Announcement.

- It is believed that increased awareness by professionals as to the purpose of the benefit and how it is implemented may contribute to increased program utilization. Therefore, the benefit will be well publicized in numerous professional newsletters and/or periodicals.

Announcing:

Full coverage second opinion benefits for Medicare Part B beneficiaries.

Starting May 22, 1978, more than 1 million Greater New Yorkers can get second surgical opinion benefits at no cost by calling our Referral Center. Read the highlights and note the number.

Blue Cross and Blue Shield of Greater New York has been chosen by the U.S. Department of Health, Education and Welfare to administer this extra Medicare benefit as part of a three-year experimental program.

The purpose: to give Greater New York residents with Part B Medicare, who have seen a surgeon regarding elective surgery, full coverage for a second opinion.

Right now second opinion benefits are available as part of your regular Medicare Part B coverage. However, you must meet the deductible and pay 20% of the charges. But under this new program, second opinions (including necessary X-rays and lab tests ordered by the consulting surgeon) will be covered in full.

Only two areas in the nation have been selected to test this benefit. Our Greater New York area is one of them—New York's five boroughs. Plus Nassau, Suffolk, Westchester, Rockland, Putnam, Dutchess, Orange, Ulster, Sullivan, Columbia, Greene and Delaware counties.

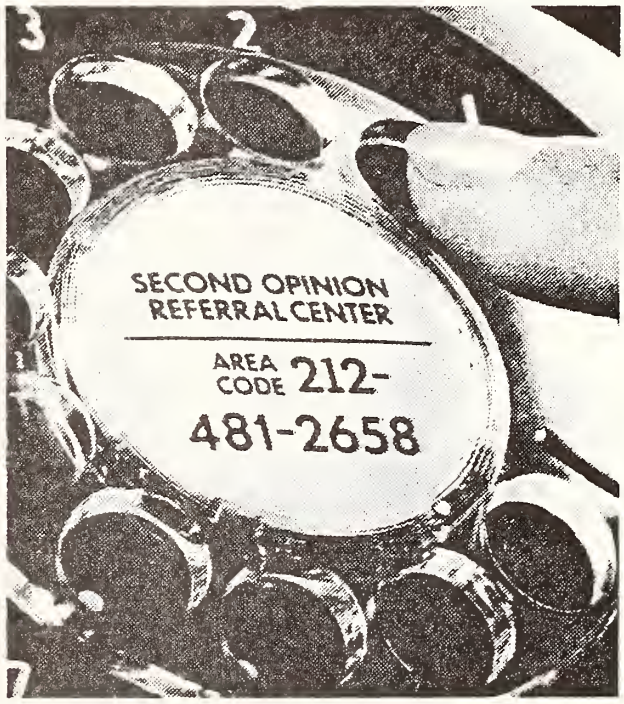
If you live in our coverage area and have Part B Medicare, you're eligible.

CALL US FIRST.

To get a fully covered second opinion you must arrange your consultation through our Referral Center. All it takes is a phone call to 212-481-2658.

Trained personnel will answer your questions and confirm your eligibility.

You'll be given the names of three board-certified surgeons in your area.



You select the one you want to see. This consultation can be arranged in complete confidence, if you wish.

Under this benefit, second opinion and even third opinion surgeon's fees, tests and X-rays will be covered in full—even in cases where the initial surgeon does not recommend an operation.

Free Brochure.

If you'd like more information, write for our free brochure at the following address: Blue Cross and Blue Shield of Greater New York, P.O. Box 551, Murray Hill Station, N.Y., N.Y. 10016.

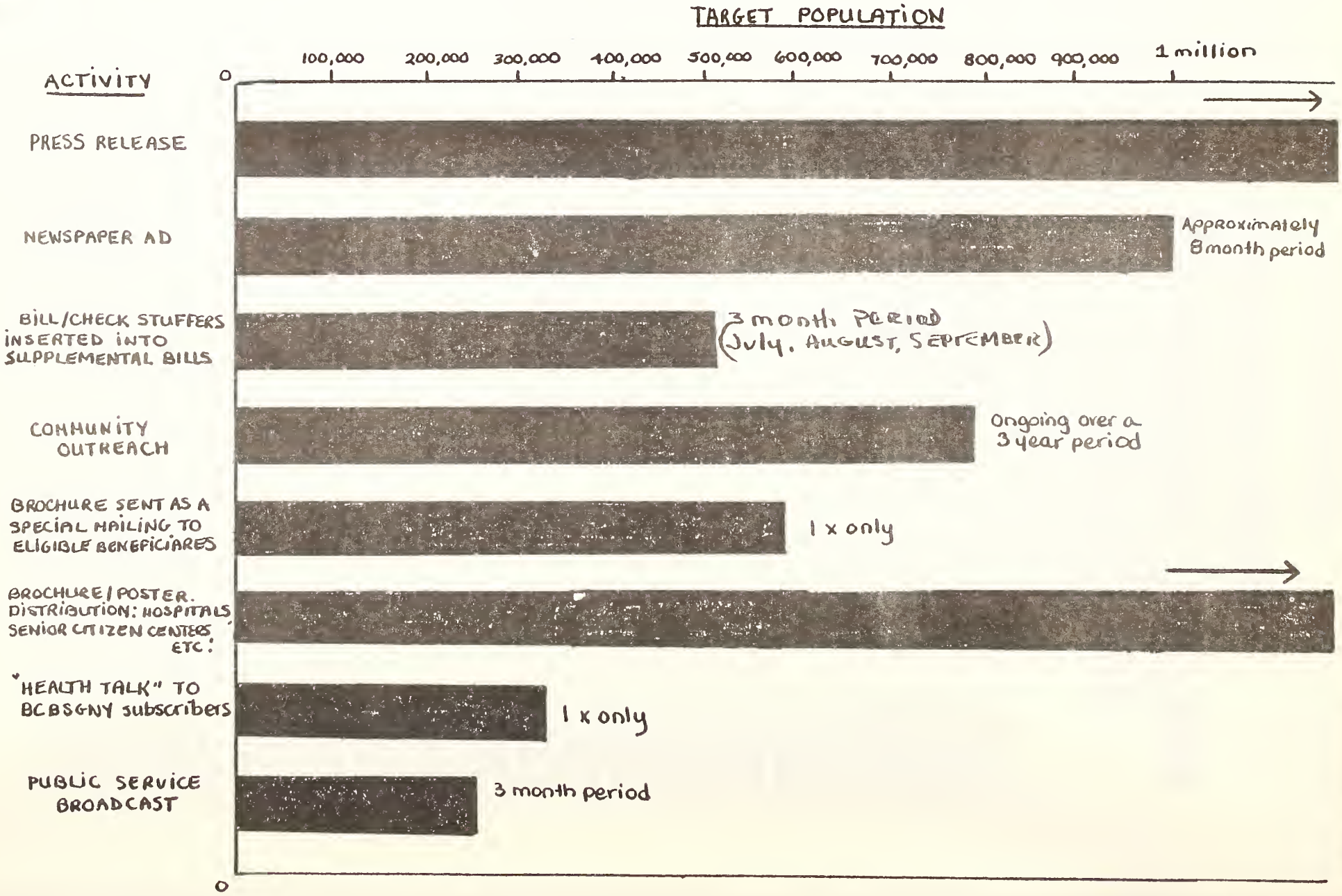
Blue Cross
Blue Shield
of Greater New York

®Registered mark Blue Cross Association
®'Registered Service Mark of the National Association of Blue Shield Plans

GRAPH — MODALITY: EDUCATIONAL/MARKETING PLAN

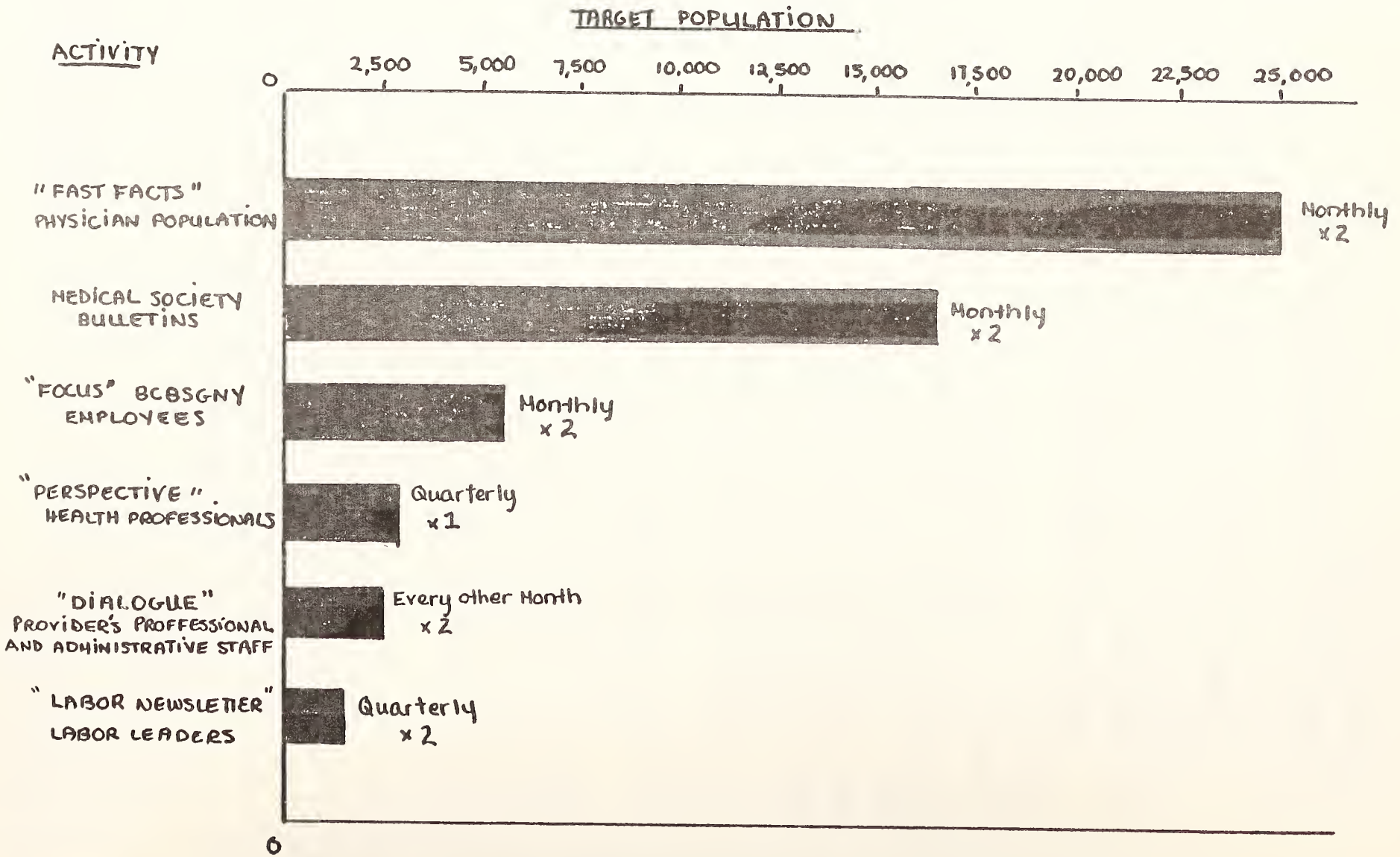
MEDICARE SECOND OPINION EXPERIMENT

PUBLIC CONTACTS



GRAPH — MODALITY : EDUCATIONAL/MARKETING PLAN — MEDICARE SECOND OPINION EXPERIMENT

PROFESSIONAL CONTACTS



Blue Cross
Blue Shield
of Greater New York

622 Third Avenue, New York, N.Y. 10017

NEWS RELEASE

John F. Byrnes
Communication Department
481-2346

FOR RELEASE

For close to 1.5 million persons in the Greater New York area who are 65 and older or disabled, May 22, 1978, will bring an extra Medicare benefit -- full coverage for second and third professional opinions to confirm the need for non-emergency elective surgery.

While all beneficiaries with Medicare Part B coverage receive benefits for second opinion consultations, and HEW urges them to do so, they are responsible for the Medicare deductible and co-insurance amounts. Under this special experimental program, however, eligible beneficiaries can obtain consultations regarding elective surgery at no cost.

Blue Cross and Blue Shield of Greater New York has been chosen by HEW to administer this experimental benefit for a three-year period. It will be available to all Medicare beneficiaries who are enrolled for Part B coverage for doctor services in New York City and 12 other counties in lower New York State -- Nassau, Suffolk, Westchester, Rockland, Putnam, Dutchess, Orange, Ulster, Sullivan, Columbia, Greene and Delaware.

The objective of the program is to determine whether this coverage will improve the quality of health care and help to contain costs under the Medicare program. The experience accumulated during the experimental period will be used as an aid in planning future health care services on a national basis.

Blue Cross and Blue Shield of Greater New York has almost two years of experience in providing similar coverage for its under-65 subscribers.

It already has in operation a Second Opinion Referral Center, and a panel of 1,700 cooperating Board-certified surgical specialists who have agreed to examine patients.

The experimental Medicare program will operate similarly to the present Blue Cross and Blue Shield Second Opinion Program. After seeing a surgeon regarding an elective surgical procedure, an eligible beneficiary will call the Plan's Second Opinion Referral Center, (212) 481-2658. The Center will furnish the names of three cooperating surgeons who are specialists in the recommended procedure, from which the beneficiary will select one to examine him and render the second opinion. Any beneficiary who wishes to do so may also use the same procedure to obtain full coverage for a third specialist's opinion.

The second and third opinion surgeons' fees, and the cost of any required X-rays and laboratory tests, will be covered in full, so there is absolutely no cost to the beneficiary.

Any beneficiary who decides to have the operation will receive all the hospital and doctor benefits in connection with the surgery which are routinely covered by Medicare, regardless of whether the second opinion consultation confirms or does not confirm the need for surgery.

Another feature of the Medicare experimental program will permit coverage for a second opinion even when the initial surgeon does not recommend surgery.

All information regarding the second and third opinions will be held confidential. At the beneficiary's request, the original surgeon will not be notified that a consultation has been held.

Enrollment for Medicare Part B is completely voluntary, at a current monthly cost of $7.70. Part A, which covers hospital care, is available without cost to all Medicare beneficiaries.

PUBLIC SERVICE ANNOUNCEMENT

BLUE CROSS AND BLUE SHIELD OF
GREATER NEW YORK
MEDICARE SECOND OPINION
30-SECOND RADIO SCRIPT
MARCH 20, 1978
REVISED

"Attention Part B Medicare beneficiaries. Starting May 22nd, Blue Cross and Blue Shield of Greater New York will begin an experimental program to help you make a decision when elective surgery is being considered. If you live in one of the 17 southern New York counties, you are eligible under this program to obtain free second and third surgical opinions on elective procedures. This means that you need not be concerned about deductibles or coinsurance.

For more information about this special Medicare benefit, call the Second Opinion Referral Center at 212-481-2658. That number again is 212-481-2658. Ask for a free brochure and get all the facts."

Blue Cross
Blue Shield
of Greater New York

622 Third Avenue, New York, N.Y. 10017

PRESSO

PROGRAM FOR ELECTIVE
SURGICAL SECOND OPINION

Dear Administrator:

As you may be aware, the Department of Health, Education and Welfare (HEW) is involved in a major effort to encourage the American public, and especially its own beneficiaries, to seek second opinions prior to elective surgery.

In addition, Blue Cross and Blue Shield of Greater New York has been selected by the Health Care Financing Administration, HEW, to administer an experimental second surgical opinion program to Medicare Part B beneficiaries over a three-year period beginning in May 1978. Two of the unique aspects of this experimental program, as distinguished from HEW's national effort, include waiver of Medicare Part B copayment and deductible requirements and the establishment of a referral center to assist beneficiaries in locating surgical consultants. This program will be carefully evaluated to determine whether the availability of the second opinion benefit improves the quality of health care as well as helps to contain its costs.

The purpose of this letter is to solicit your support in our experimental endeavor. In particular, we would appreciate your agreement to display special posters and brochures in your clinics, ambulatory care centers, waiting rooms or any area used frequently by out-patient Medicare beneficiaries or their relatives. Copies of these materials designed to advertise this cost-free benefit to eligible beneficiaries are enclosed.

Should you wish additional copies, please contact your Blue Cross and Blue Shield of Greater New York Provider Representative.

Sincerely,

Ruth Haase

Ruth Haase,
Assistant Vice President

RH/rb

Blue Cross
Blue Shield
of Greater New York

MEDICARE

622 Third Avenue, New York, N.Y. 1001

Date _____

Dear District Manager:

As you no doubt know, the Department of Health, Education and Welfare is involved in a major effort to encourage the American public, and especially its own beneficiaries, to seek second opinions prior to elective surgery.

In addition, Blue Cross and Blue Shield of Greater New York has been selected by the Health Care Financing Administration to administer an experimental second surgical opinion program to Medicare Part B beneficiaries over a three-year period beginning in May 1978. Two of the unique aspects of this experimental program, as distinguished from HEW's national effort, include waiver of Medicare Part B co-payment and deductible requirements and the establishment of a referral center to assist beneficiaries in locating surgical consultants. This program will be carefully evaluated to determine whether the availability of the second opinion benefit improves the quality of health care as well as helps to contain its costs.

As arranged with the Regional Office of the Medicare Bureau, I am enclosing brochures and special posters to be displayed in your District Offices.

We greatly appreciate your cooperation in coordination of this endeavor. Should you wish additional materials, or any further information regarding the experimental program, please feel free to contact me.

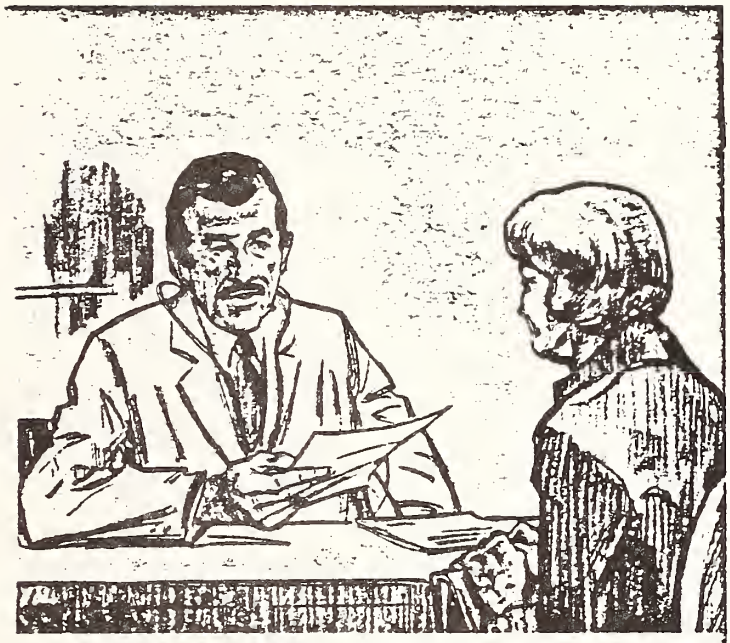
Sincerely,

Patricia O'Connor

Patricia O'Connor, Coordinator
Program for Elective Surgical
Second Opinion
481-2658

POC:ac

SAMPLE BROCHURE COVER



When Elective Surgery is being considered, you may be eligible for a

FREE SECOND OPINION

Now, each eligible beneficiary enrolled in Medicare Part B who resides in one of the 17 southern counties of New York State, is covered by a new experimental program that offers a *free second opinion* by a cooperating board-certified surgical specialist after the beneficiary has seen a surgeon regarding elective surgery. In addition, the cost of any X-ray or laboratory tests ordered by the second opinion surgeon will be paid in full.

The purpose of this experimental program is to evaluate whether second opinion benefits will improve the quality of health care as well as help to contain costs. Most importantly, it will provide you with an additional professional opinion before you make a decision regarding elective surgery.

ELIGIBILITY REQUIREMENTS FOR COST-FREE SECOND SURGICAL OPINIONS

1. You must reside in one of the following counties of New York State:

Bronx	Nassau	Rockland
Columbia	New York	Suffolk
Delaware	Orange	Sullivan
Dutchess	Putnam	Ulster
Greene	Queens	Westchester
Kings	Richmond	

2. You must have seen a surgeon prior to your request for a second opinion.

3. Your request must be arranged through the Referral Center of Blue Cross and Blue Shield of Greater New York.

SECOND SURGICAL OPINION REFERRAL CENTER

(212) 481-2658

HOW TO ARRANGE FOR A FREE SECOND OPINION

■ Call the Referral Center at (212) 481-2658 and have on hand the following information:

1. The name and address of your surgeon (if you are a clinic patient, obtain the name and address of the surgeon you have seen regarding elective surgery);

2. The name of the surgical procedure being considered; and

3. The names of any diagnostic tests that were ordered by your surgeon.

■ The Referral Center, upon determining your eligibility, will provide you with the names of three qualified surgeons in the same specialty as your primary surgeon and who practice in a location convenient to you.

■ Select one of the three surgical specialists and make an appointment. Explain to the specialist that the appointment is for a second opinion under the Medicare Part B experimental second opinion program.

1. If you wish, this appointment can be scheduled by the staff of the Referral Center.

2. If you make the appointment yourself, call the Referral Center and give them the name of the specialist you have selected and the date of the appointment.

- A special claim form will be mailed to you.
- Should you request to see a specific surgeon for a second opinion and that physician is participating in this program, approval will be given, provided that you make arrangements through the Referral Center prior to seeing the surgical specialist.
- All surgeons participating in this program agree not to perform surgery or otherwise treat the patient for the specific condition involved.
- If desired, the second opinion request will be kept confidential from your primary surgeon.
- If after the second opinion is obtained, you are still unable to make a decision, you may request a third opinion. Arrangements for a third opinion should be made as outlined above.

In all cases, the final decision regarding elective surgery is made by you.

HOW DOCTORS REACT TO SECOND OPINIONS

In general, when a doctor recommends surgery, he or she wants the patient to feel confident that surgery is, in fact, the most appropriate treatment.

This program offers those who are eligible an opportunity to receive a second opinion before making their final decision as to whether or not to have elective surgery.

If a surgeon recommends elective surgery —or if after conferring with a surgeon you feel you need elective surgery—you may wish to have a second opinion to assist you in determining whether surgery is the most appropriate course of action. Surgery is considered elective when it can be scheduled at the convenience of the patient rather than being performed under emergency conditions.

Second opinion benefits are already available as part of your regular Medicare Part B coverage. However, you must meet the deductible and pay 20 percent of the charges under the standard coverage.

NEW EXPERIMENTAL PROGRAM OFFERS FREE SECOND SURGICAL OPINIONS

INSERT TO BE USED AS "BILL STUFFERS"

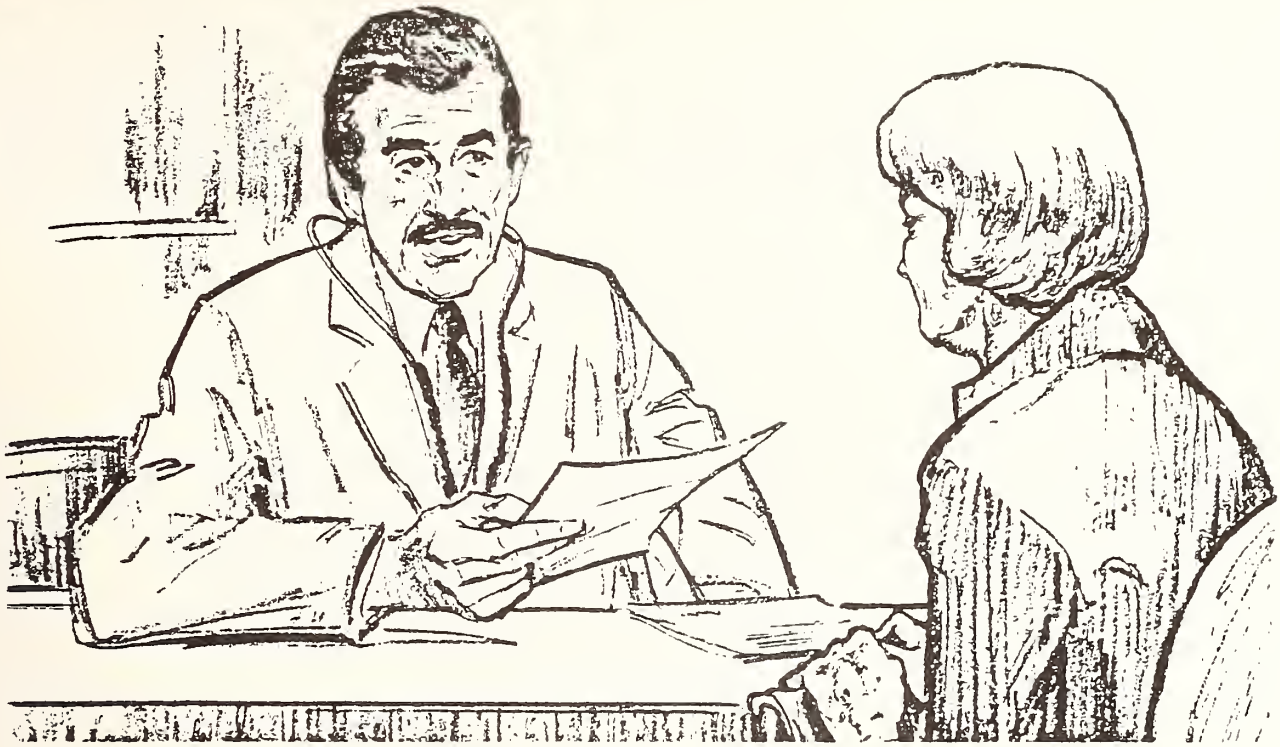
When Elective Surgery is being considered, you're now eligible for a

FREE SECOND OPINION

To help you make a decision about elective surgery, take advantage of a new experimental program which offers a free second opinion from a surgical specialist. Arrange for your second opinion by calling our Referral Center at (212) 481-2658.

A Medicare Part B Experimental Program administered by Blue Cross and Blue Shield of Greater New York

SP-205 (6-78)



When Elective Surgery is being considered, you may be eligible* for a

FREE SECOND OPINION

To help you make a decision about elective surgery, take advantage of a new experimental program which offers a free second opinion from a surgical specialist. Arrange for your second opinion by calling our Referral Center at (212) 481-2658.

A Medicare Part B Experimental Program administered by Blue Cross and Blue Shield of Greater New York

*To be eligible, you must be enrolled in Medicare Part B, have seen a surgeon regarding elective surgery, and reside in one of the following counties of New York State: Bronx, Columbia, Delaware, Dutchess, Greene, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Sullivan, Ulster or Westchester.

SP-208 (6-78)

Publication: Fast Facts
Issue: April
Subject: Medicare 2nd Opinion
Writer: Eva Schneid

medicare second opinion

experiment awarded to bcbsgny

This article will serve as the prototype for all others scheduled to be published in the following:

"Health Talk"
"Focus"
"Perspective"
"Dialogue"
Medical Society Bulletins
"Labor Newsletter"

The content of these articles will be appropriately tailored to reflect the needs of the specific audience for which they are intended.

Blue Cross and Blue Shield of Greater New York has been selected by the Department of Health, Education and Welfare to administer an experimental second surgical opinion program for 1.5 million Medicare Part B beneficiaries.

HEW is currently developing an approach to encourage the public, and especially the beneficiaries HEW serves, to seek a second opinion before elective surgery. HEW will use the results of the BCBSGNY experiment to determine whether second opinion coverage improves the quality of care, while helping to contain costs under the Medicare program.

The main difference between the experimental program BCBSGNY will administer and the national effort HEW is designing is that beneficiaries covered under the experiment have no coinsurance or deductible liability for the consultant's fee or any of the X-ray or laboratory tests the consultant orders.

This three year cost-free experimental benefit becomes available in May 1978 to beneficiaries in the 17 county area for which BCBSGNY has been the Medicare Part B Carrier since the program's inception. Beneficiaries who receive services in Queens will also be eligible for this benefit.

End ( ) More ( )

BCBSGNY's Second Opinion Referral

Publication: _____
Issue: _____
Subject: _____
Writer: _____

Center, which has been directing a similar program for non-Medicare BCBSGNY subscribers for the past two years, will coordinate the demonstration project.

After seeing a surgeon regarding an elective surgical procedure, eligible beneficiaries who wish to obtain a second opinion can do so. To be covered by the benefit, the beneficiary must make arrangements through the Center, which will furnish the names of three surgeons; the patient then chooses one. Whenever possible, the specialist will be located conveniently for the patient, and will represent the same specialty as the surgeon already seen.

About 1,500 American Board Certified surgical specialists are enrolled with the program, and have agreed to examine patients and render the second opinion.

Whether or not the consultation confirms the need for surgery, any beneficiary who decides to undergo surgery will receive all the benefits which are routinely covered by Medicare. The Medicare deductible and coinsurance for these services are the beneficiary's responsibility.

Another feature of the Medicare Project permits coverage of second opinions even when the initial surgeon does not recommend surgery. A third opinion is

End ( ) More ( )

also covered, should the patient wish it, provided that arrangements for it are made through the Center.

While surgeon-to-surgeon dialogue is encouraged, the program will respect a beneficiary's request for confidentiality.

Physicians who want further information, and surgeons who wish to participate in the program, can call the Second Opinion Referral Center at 481-2658, or write to Blue Cross and Blue Shield of Greater New York, Box 551, New York, NY 10016.

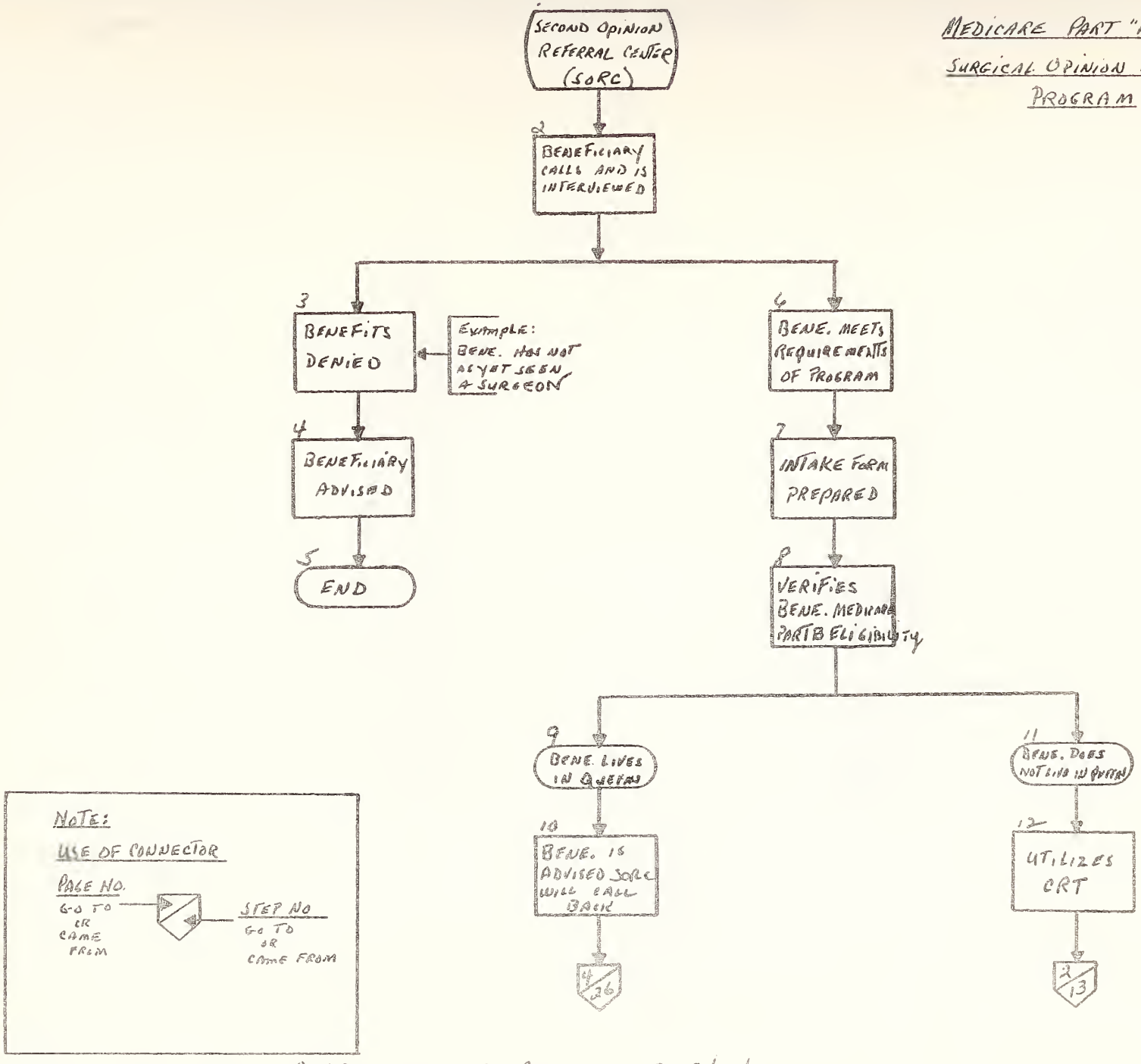
End ( ) More ( )

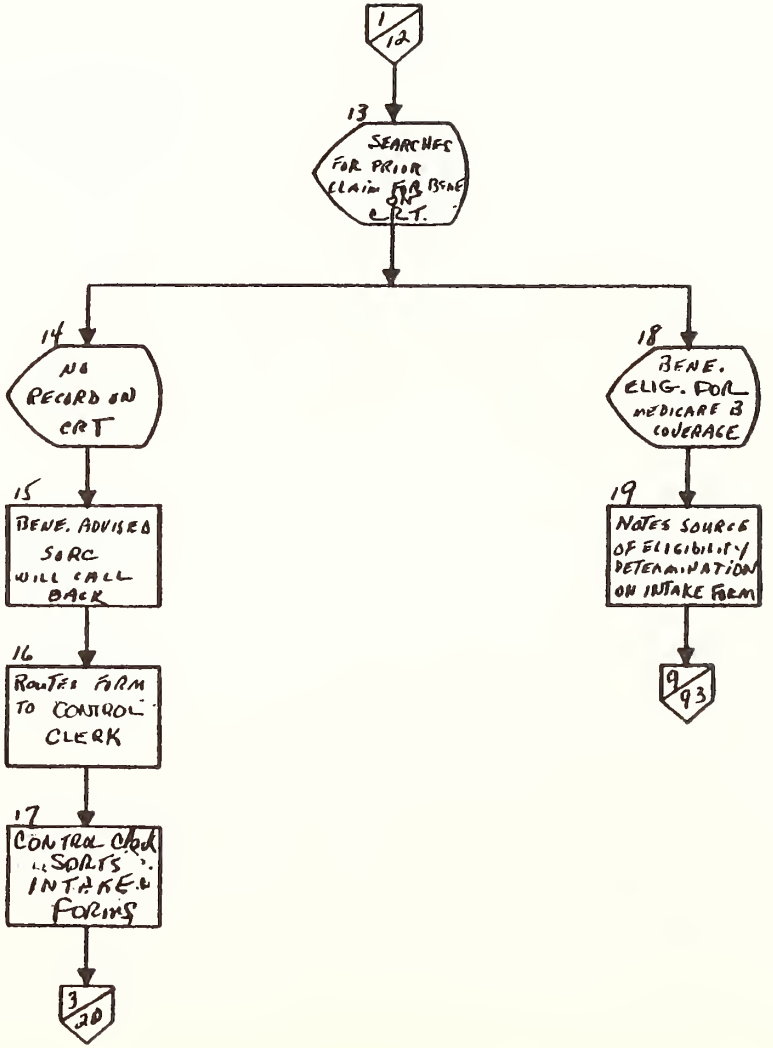
The following flow charts describe the mechanisms by which the Medicare Part B Second Surgical Opinion Experiment will be implemented.

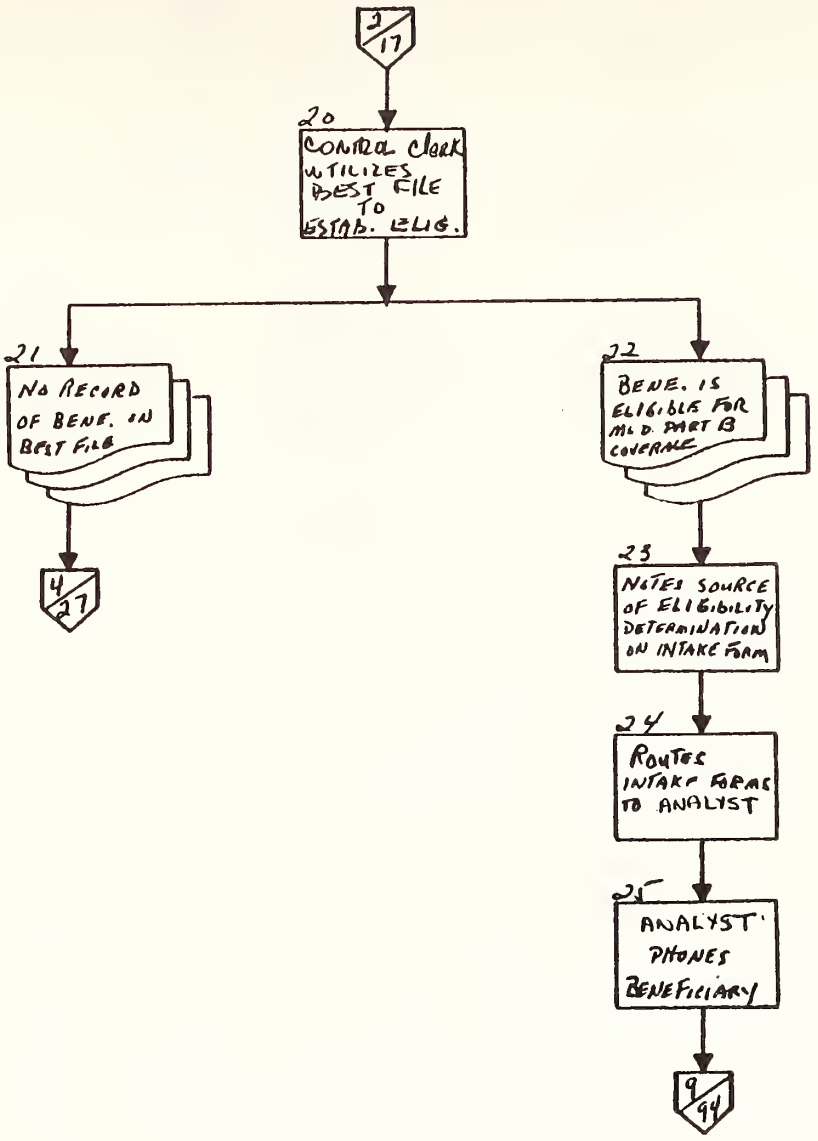
Not all of these mechanisms require accompanying narrative description for understanding.

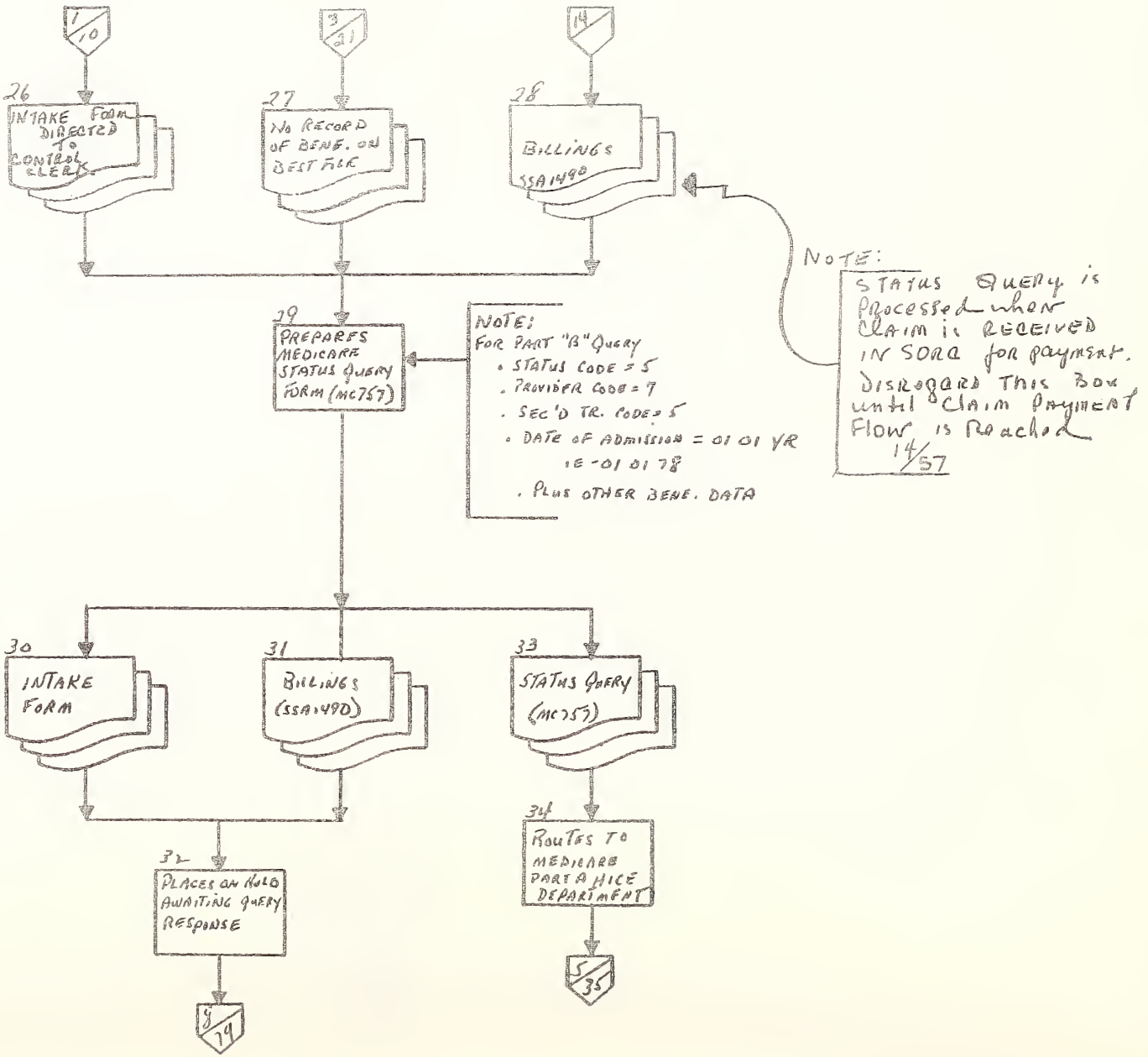
However, some are the result of definitive policy decisions, the application of which significantly impacts on the Program's direction. Because of their importance, they will be individually addressed in the "Policy and Procedure" portion of this report, immediately following these flow charts.

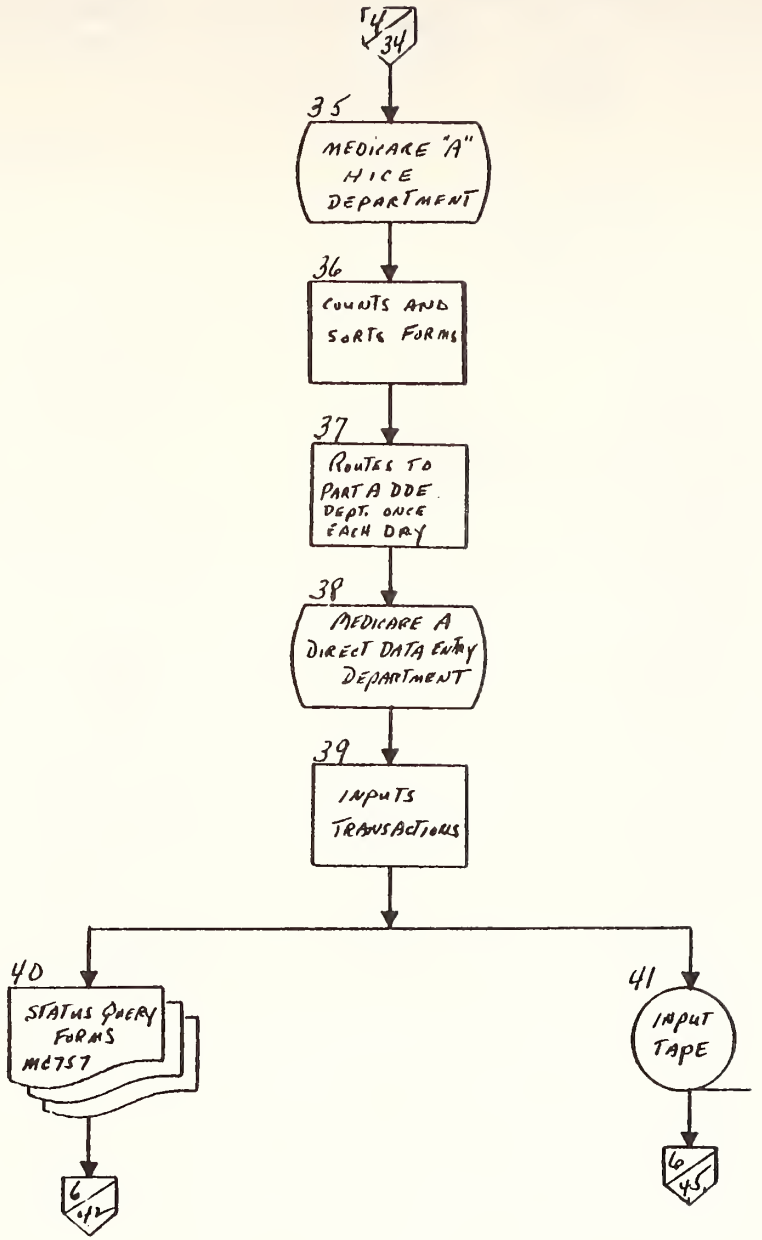
MEDICARE PART "B" SECOND SURGICAL OPINION EXPERIMENTAL PROGRAM

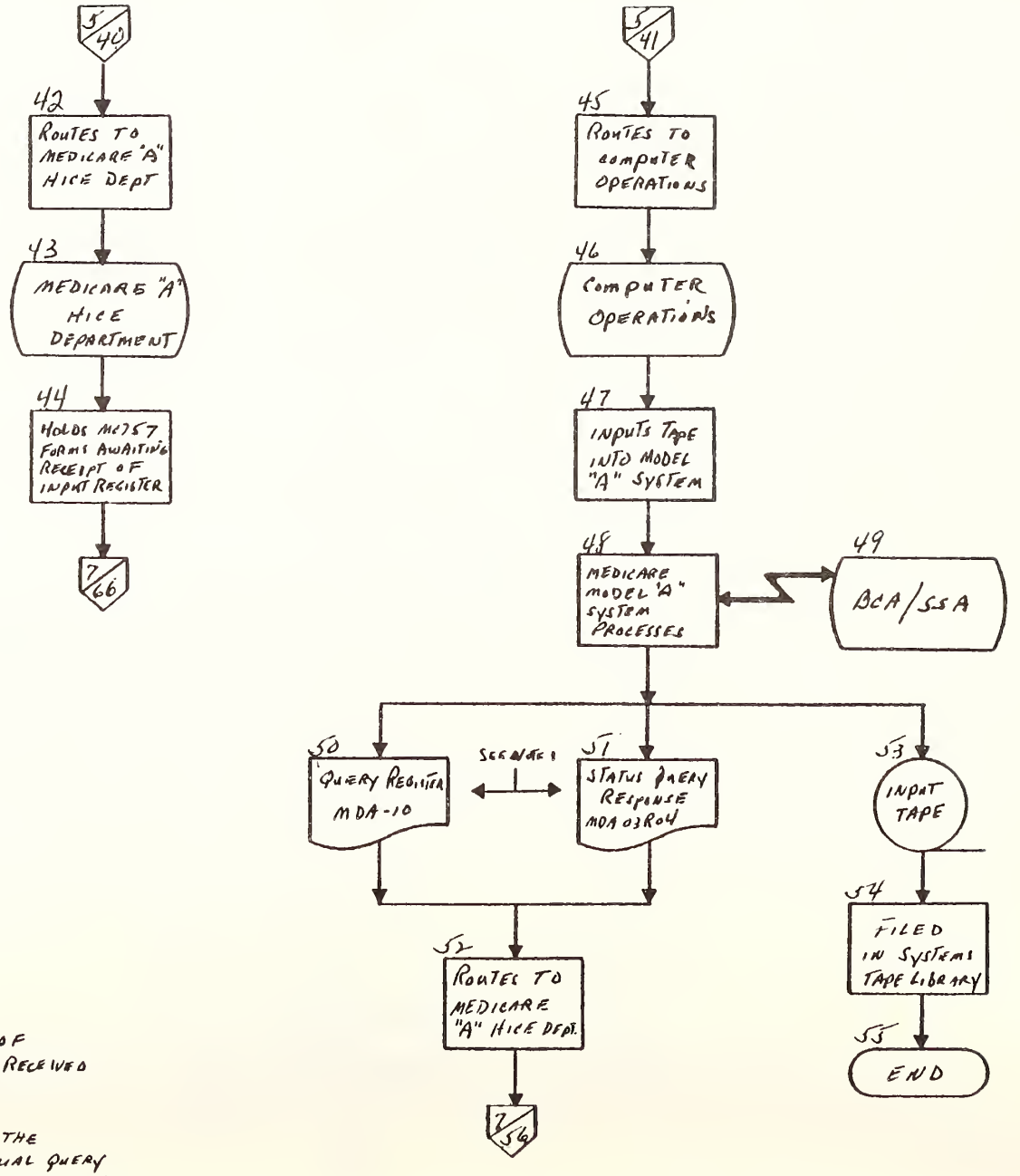



1/12
13
SEARCHES FOR PRIOR CLAIM FOR BENE ON CRT.
14
NO RECORD ON CRT
15
BENE. ADVISED SOMC WILL CALL BACK
16
ROUTES FORM TO CONTROL CLERK
17
CONTROL CLK SORTS INTAKE FORMS
3/20
18
BENE. ELIG. FOR MEDICARE B COVERAGE
19
NOTES SOURCE OF ELIGIBILITY DETERMINATION ON INTAKE FORM
9/93


3/17
20
CONTROL CLERK UTILIZES BEST FILE TO ESTAB. ELIG.
21
NO RECORD OF BENE. IN BEST FILE
4/27
22
BENE. IS ELIGIBLE FOR MED. PART B COVERAGE
23
NOTES SOURCE OF ELIGIBILITY DETERMINATION ON INTAKE FORM
24
ROUTES INTAKE FORMS TO ANALYST
25
ANALYST PHONES BENEFICIARY
9/94


1/10
3/21
14
26
INTAKE FORM DIRECTED TO CONTROL CLERK
27
NO RECORD OF BENE. ON BEST FILE
28
BILLINGS SSA1490
NOTE:
STATUS QUERY is processed when CLAIM is RECEIVED IN SORC for payment. DISREGARD THIS BOX until CLAIM PAYMENT FLOW is Reached
1/4/57
29
PREPARES MEDICARE STATUS QUERY FORM (MC757)
NOTE:
FOR PART "B" QUERY
• STATUS CODE = 5
• PROVIDER CODE = 7
• SEC'D TR. CODE = 5
• DATE OF ADMISSION = 01 01 YR
IE - 01 01 78
• PLUS OTHER BENE. DATA
30
INTAKE FORM
31
BILLINGS (SSA1490)
33
STATUS QUERY (MC757)
32
PLACES ON HOLD AWAITING QUERY RESPONSE
34
ROUTES TO MEDICARE PART A HICE DEPARTMENT
5/35
9/29

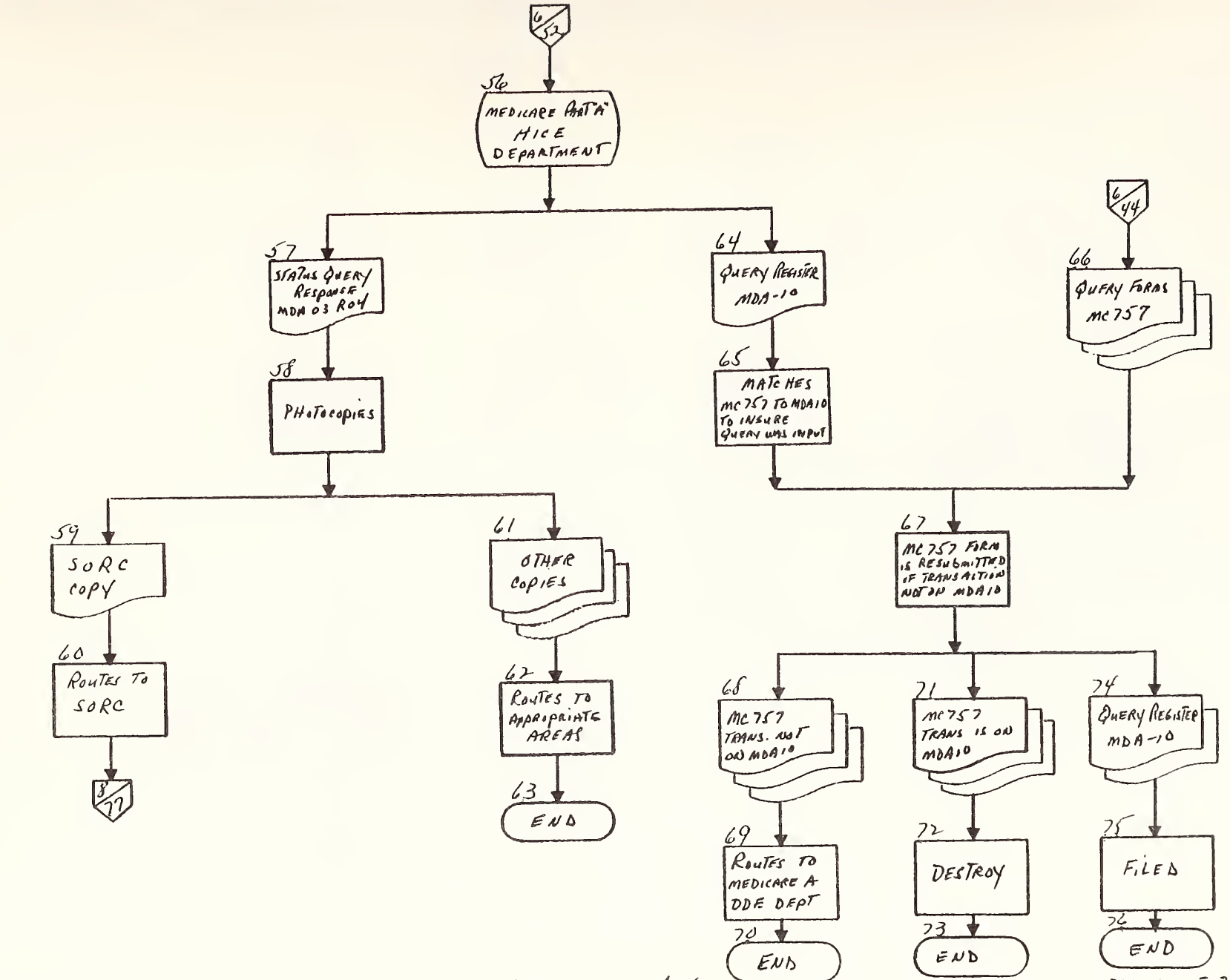

4/34
35
MEDICARE "A" HICE DEPARTMENT
36
COUNTS AND SORTS FORMS
37
ROUTES TO PART A DDE DEPT. ONCE EACH DAY
38
MEDICARE A DIRECT DATA ENTRY DEPARTMENT
39
INPUTS TRANSACTIONS
40
STATUS QUERY FORMS MC757
41
INPUT TAPE
6/42
6/45



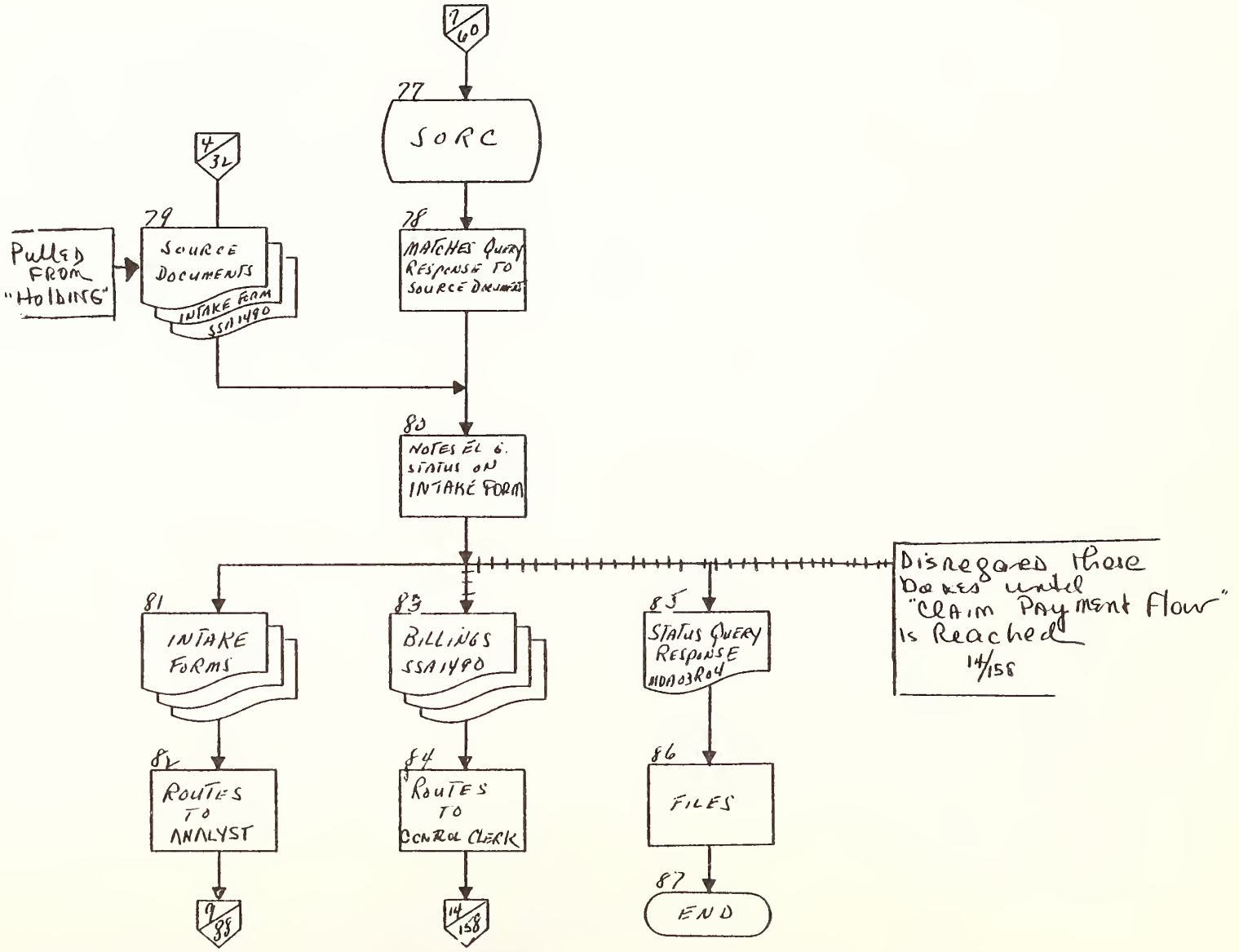
NOTE 1

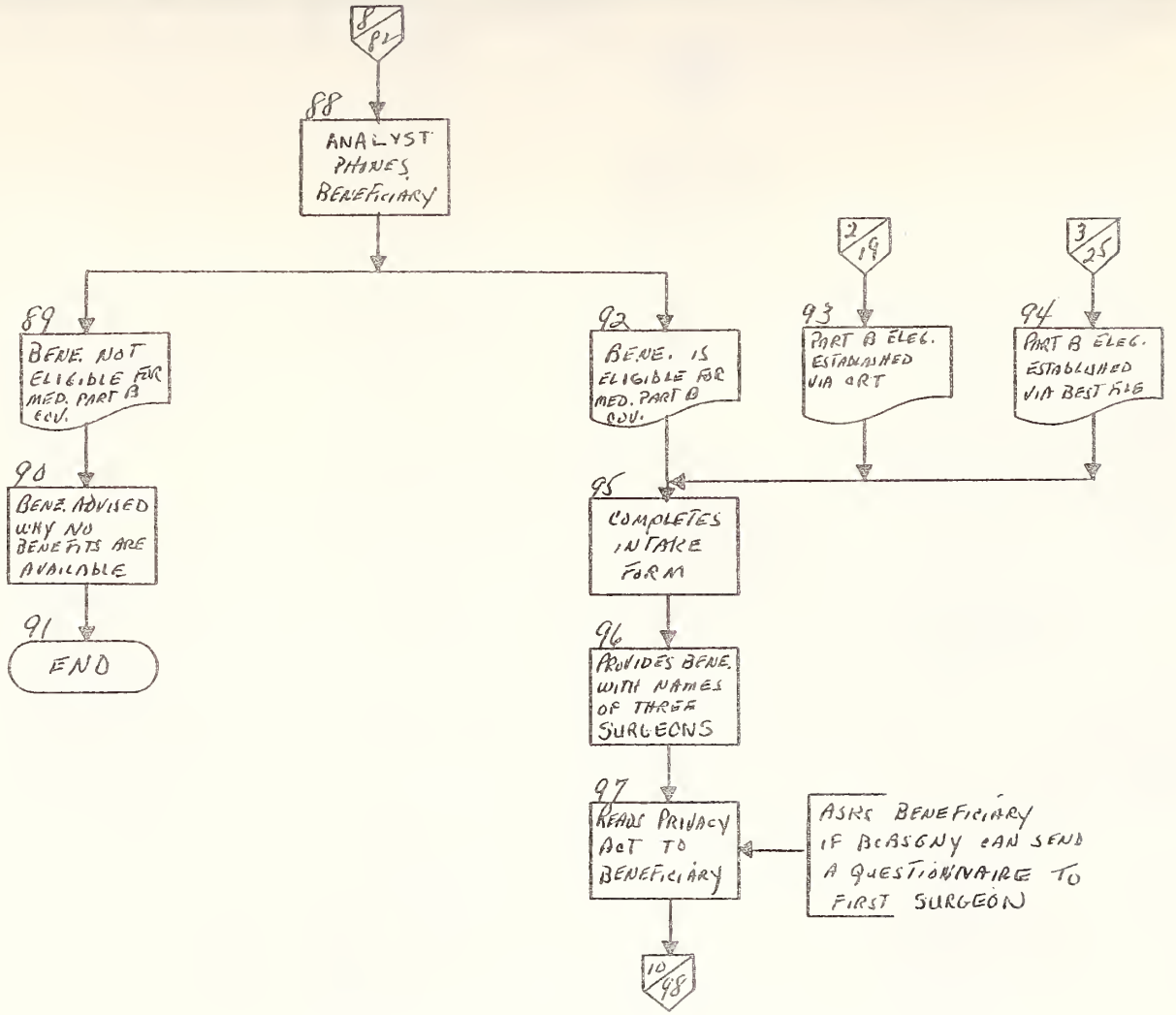
QUERY REGISTER IS RECORD OF INPUT TRANSACTIONS AND IS RECEIVED THE NEXT DAY

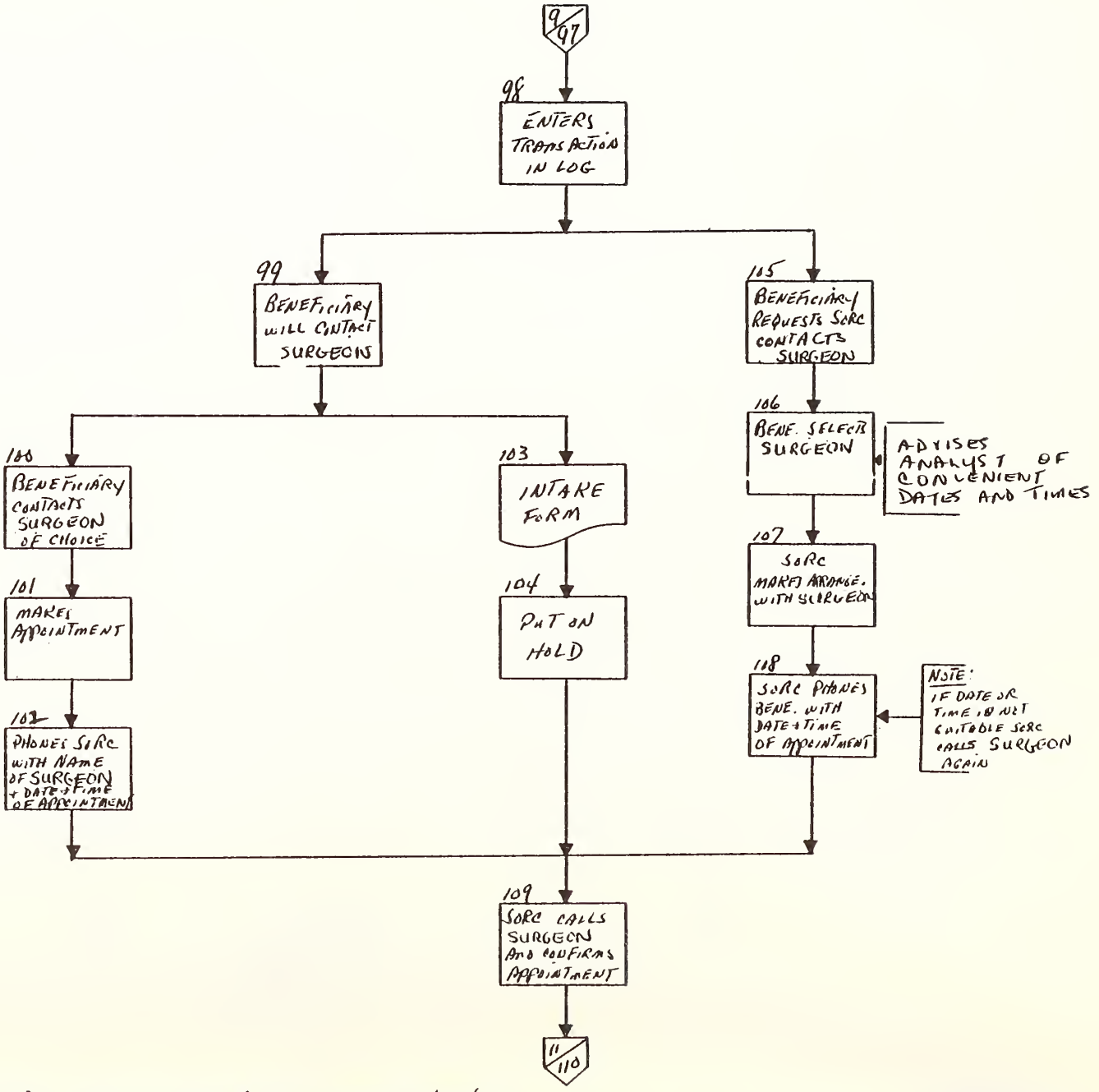
STATUS QUERY RESPONSE IS THE REPLY TO THE QUERY. INDIVIDUAL QUERY RESPONSES TAKE FROM 2 DAYS TO MONTHS DEPENDING ON SSA'S ABILITY TO LOCATE THE BENEFICIARYS' ELIGIBILITY STATUS

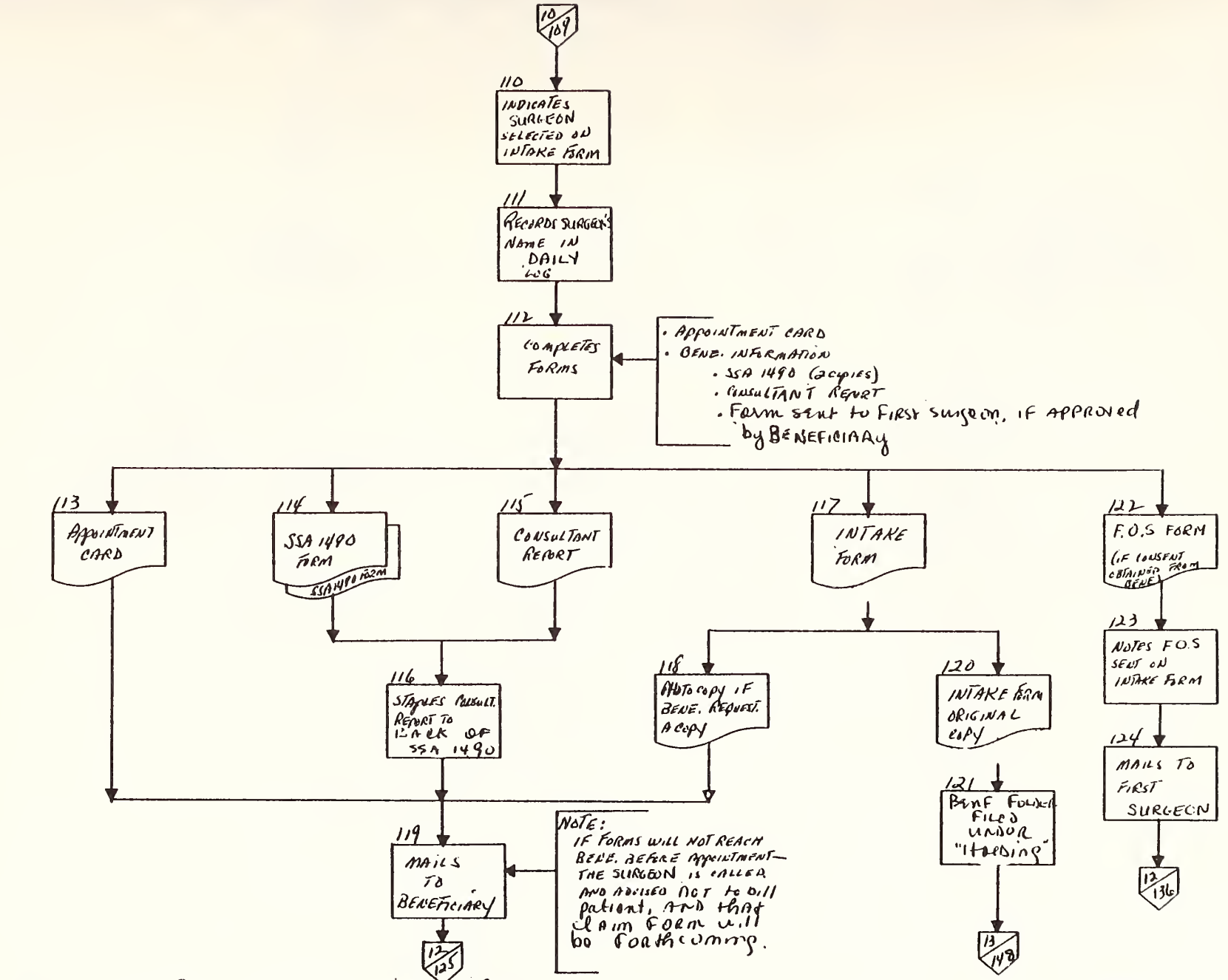


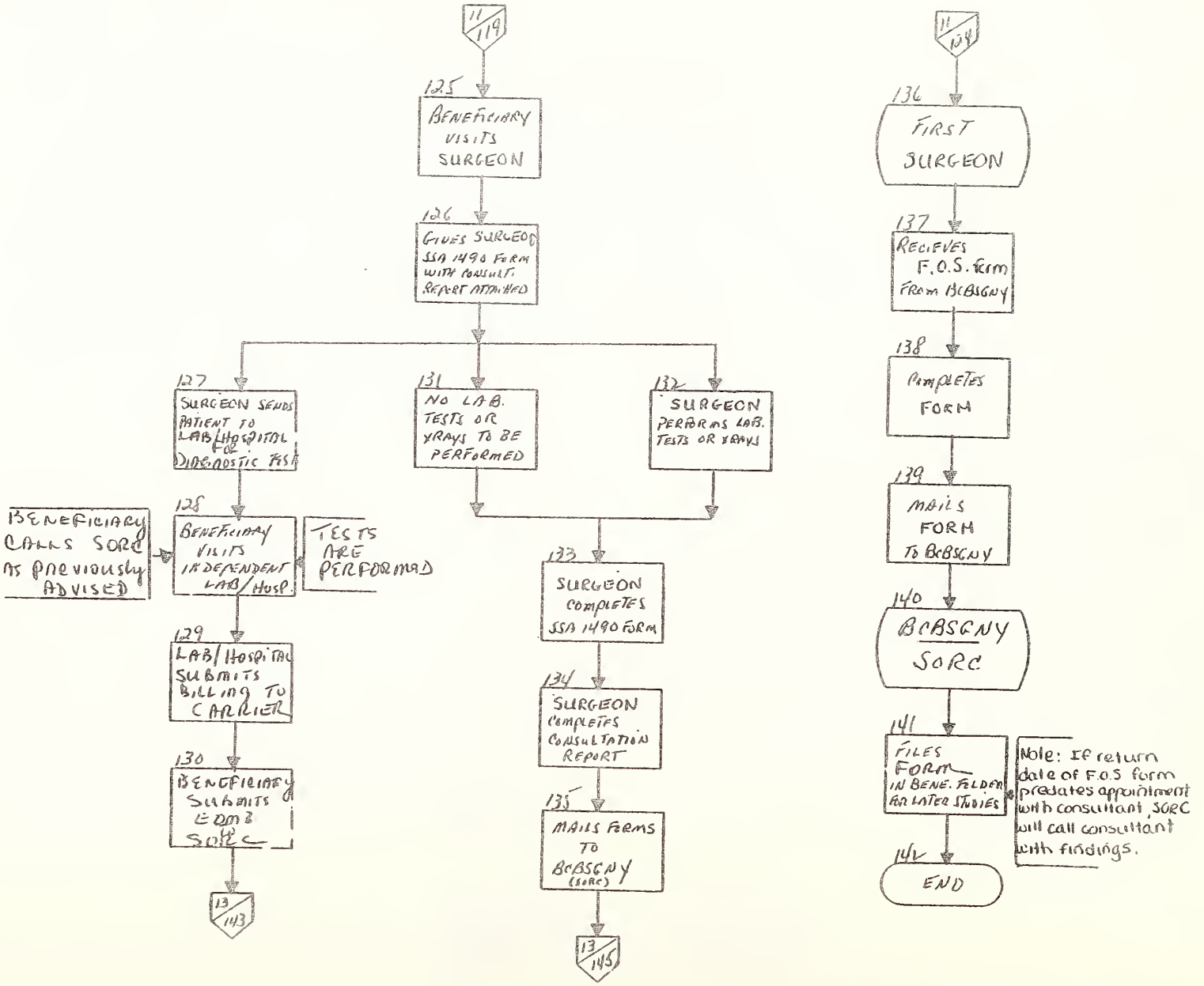
MEDICARE SECOND SURGICAL OPINION EXPERIMENTAL PROGRAM DATE 3/30/78

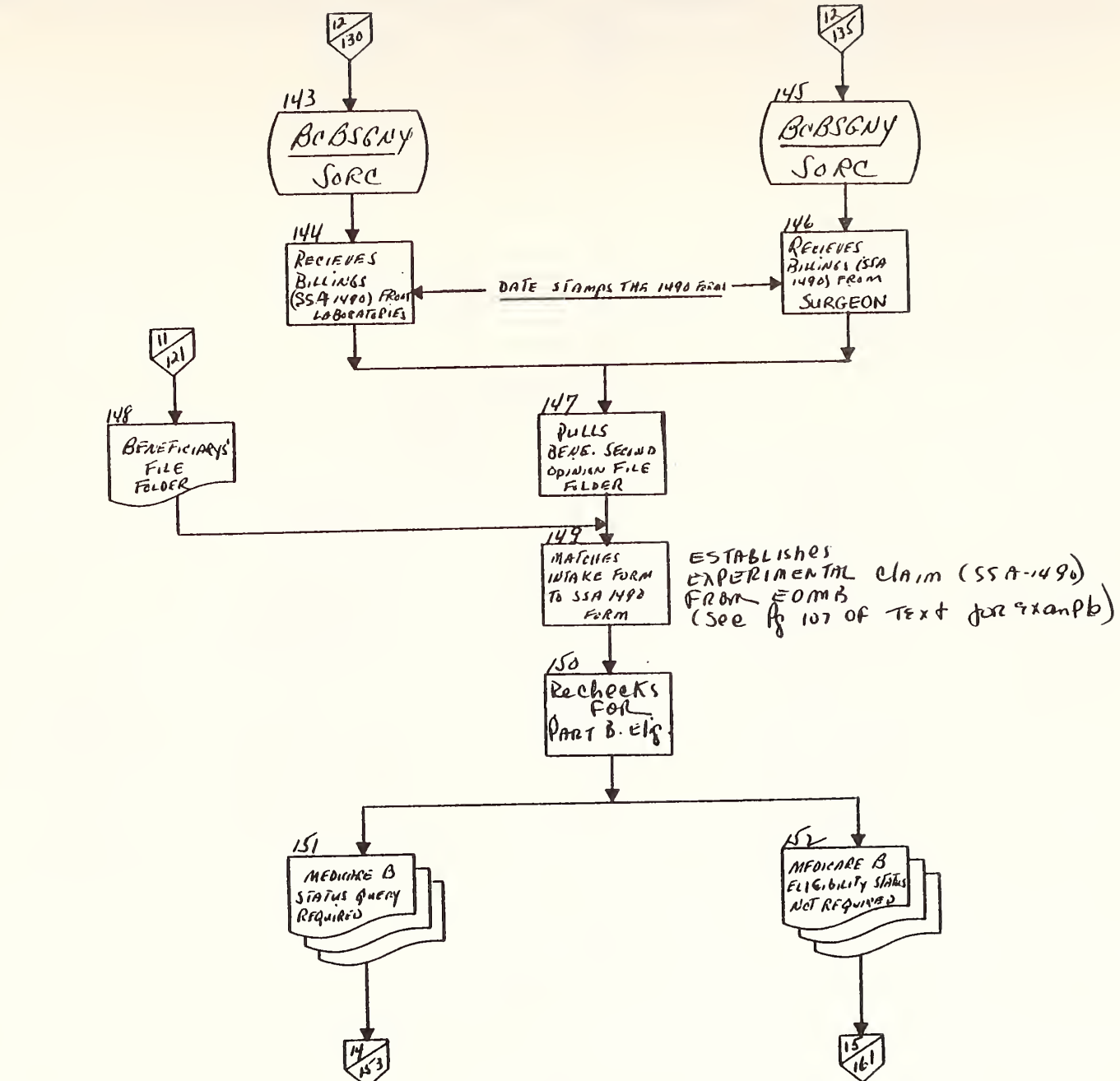

7/60
77
SORC
4/32
79
SOURCE DOCUMENTS
INTAKE FORM SSA1490
PULLED FROM "HOLDING"
78
MATCHES QUERY RESPONSE TO SOURCE DOCUMENTS
80
NOTES EL & STATUS ON INTAKE FORM
Disregard these boxes until "Claim Payment Flow" is Reached 14/158
81
INTAKE FORMS
83
BILLINGS SSA1490
85
STATUS QUERY RESPONSE HDA03R04
82
ROUTES TO ANALYST
9/38
84
ROUTES TO CONTROL CLERK
14/158
86
FILES
87
END


8/91
88
ANALYST PHONES BENEFICIARY
89
BENE. NOT ELIGIBLE FOR MED. PART B COV.
90
BENE. ADVISED WHY NO BENEFITS ARE AVAILABLE
91
END
92
BENE. IS ELIGIBLE FOR MED. PART B COV.
2/19
93
PART B ELEC. ESTABLISHED VIA CRT
3/25
94
PART B ELEC. ESTABLISHED VIA BEST FILE
95
COMPLETES INTAKE FORM
96
PROVIDES BENE. WITH NAMES OF THREE SURGEONS
97
READS PRIVACY ACT TO BENEFICIARY
ASKS BENEFICIARY IF BCASGNY CAN SEND A QUESTIONNAIRE TO FIRST SURGEON
10/98

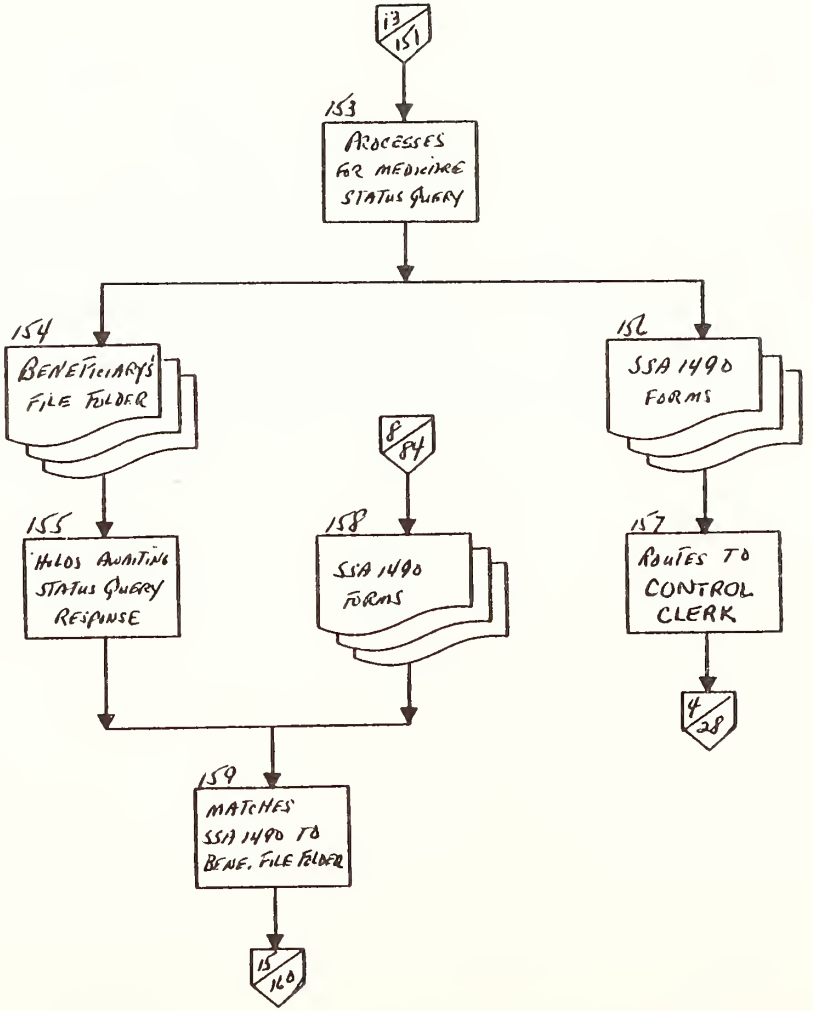

9/97
98
ENTERS TRANSACTION IN LOG
99
BENEFICIARY WILL CONTACT SURGEON
105
BENEFICIARY REQUESTS SORC CONTACTS SURGEON
100
BENEFICIARY CONTACTS SURGEON OF CHOICE
101
MAKES APPOINTMENT
102
PHONES SORC WITH NAME OF SURGEON + DATE + TIME OF APPOINTMENT
103
INTAKE FORM
104
PUT ON HOLD
106
BENE. SELECT SURGEON
ADVISES ANALYST OF CONVENIENT DATES AND TIMES
107
SORC MAKES ARRANGE. WITH SURGEON
108
SORC PHONES BENE. WITH DATE + TIME OF APPOINTMENT
NOTE: IF DATE OR TIME IS NOT SUITABLE SORC CALLS SURGEON AGAIN
109
SORC CALLS SURGEON AND CONFIRMS APPOINTMENT
11/110

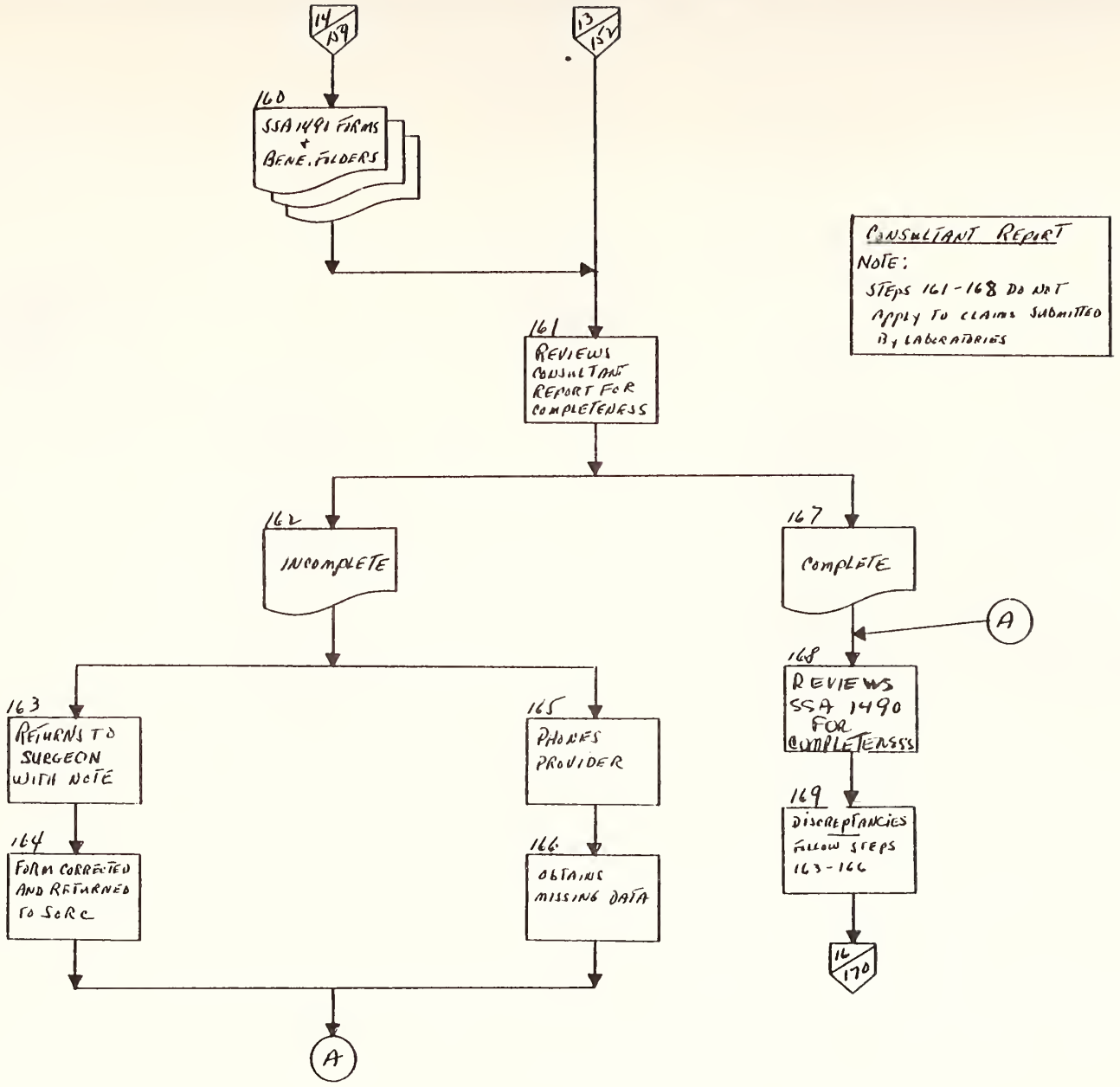

10/169
110
INDICATES SURGEON SELECTED ON INTAKE FORM
111
RECORDS SURGEON'S NAME IN DAILY LOG
112
COMPLETES FORMS
• APPOINTMENT CARD
• BENE. INFORMATION
• SSA 1490 (2 copies)
• CONSULTANT REPORT
• FORM SENT TO FIRST SURGEON, IF APPROVED by BENEFICIARY
113
APPOINTMENT CARD
114
SSA 1490 FORM
SSA 1490 FORM
115
CONSULTANT REPORT
116
STAPLES CONSULT. REPORT TO BACK OF SSA 1490
117
INTAKE FORM
118
PHOTO COPY IF BENE. REQUEST A COPY
120
INTAKE FORM ORIGINAL COPY
121
BENF FOLDER FILED UNDER "HOLDING"
13/148
122
F.O.S FORM
(IF CONSENT OBTAINED FROM BENE.)
123
NOTES F.O.S SENT ON INTAKE FORM
124
MAILS TO FIRST SURGEON
13/136
119
MAILS TO BENEFICIARY
13/125
NOTE:
IF FORMS WILL NOT REACH BENE. BEFORE APPOINTMENT— THE SURGEON IS CALLED AND ADVISED NOT TO bill patient, AND THAT CLAIM FORM will be forthcoming.

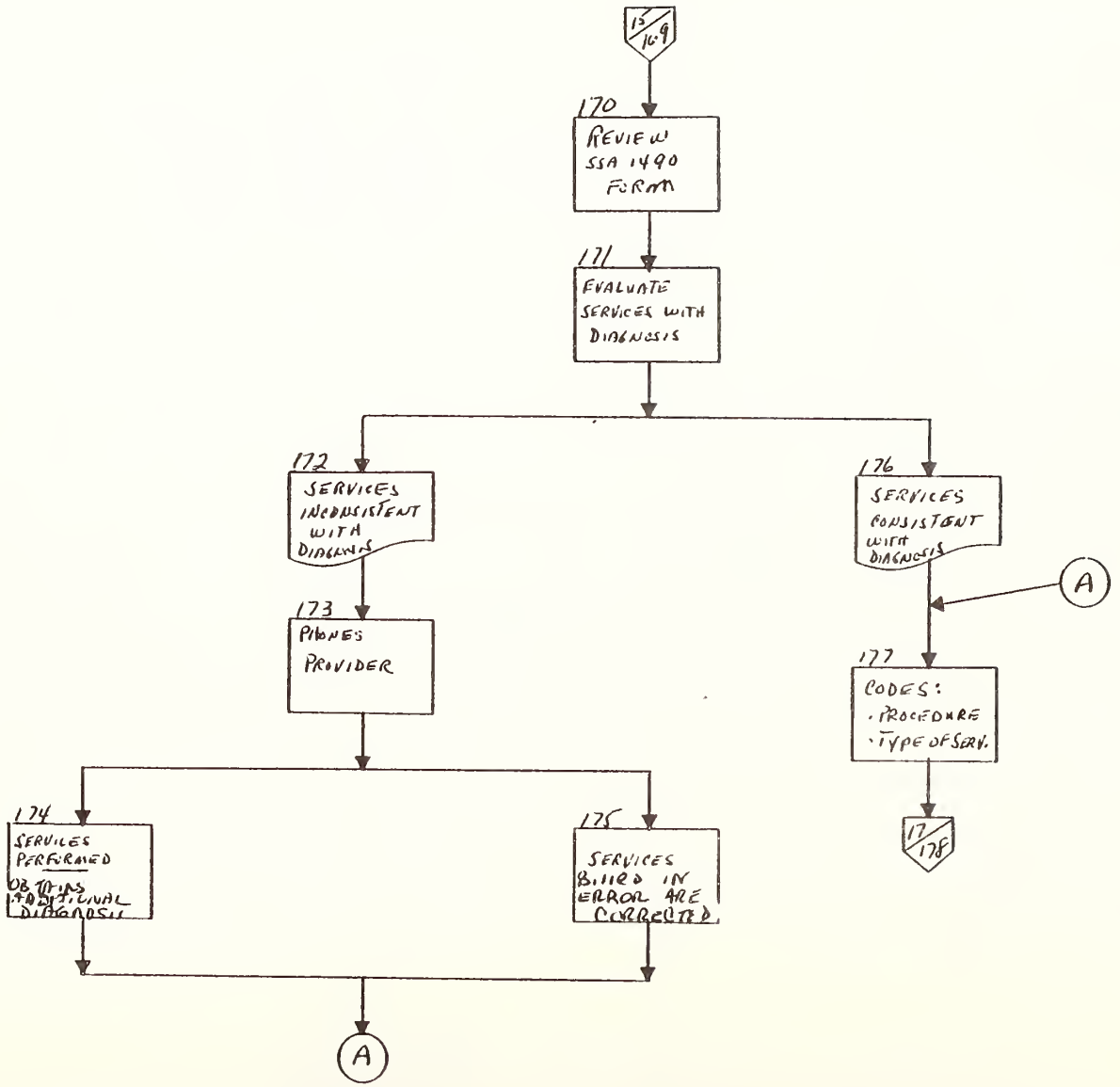

11/119
125
BENEFICIARY VISITS SURGEON
126
GIVES SURGEON SSA 1490 FORM WITH CONSULT. REPORT ATTACHED
127
SURGEON SENDS PATIENT TO LAB/HOSPITAL FOR DIAGNOSTIC TESTS
131
NO LAB. TESTS OR XRAYS TO BE PERFORMED
132
SURGEON PERFORMS LAB. TESTS OR XRAYS
128
BENEFICIARY VISITS INDEPENDENT LAB/HOSP.
BENEFICIARY CALLS SORC AS PREVIOUSLY ADVISED
TESTS ARE PERFORMED
129
LAB/HOSPITAL SUBMITS BILLING TO CARRIER
130
BENEFICIARY SUBMITS FORM TO SORC
13/143
133
SURGEON COMPLETES SSA 1490 FORM
134
SURGEON COMPLETES CONSULTATION REPORT
135
MAILS FORMS TO BCBSGNY (SORC)
13/145
11/134
136
FIRST SURGEON
137
RECIEVES F.O.S. form FROM BCBSGNY
138
COMPLETES FORM
139
MAILS FORM TO BCBSGNY
140
BCBSGNY SORC
141
FILES FORM IN BENE. FOLDER FOR LATER STUDIES
Note: If return date of F.O.S form predates appointment with consultant, SORC will call consultant with findings.
14V
END

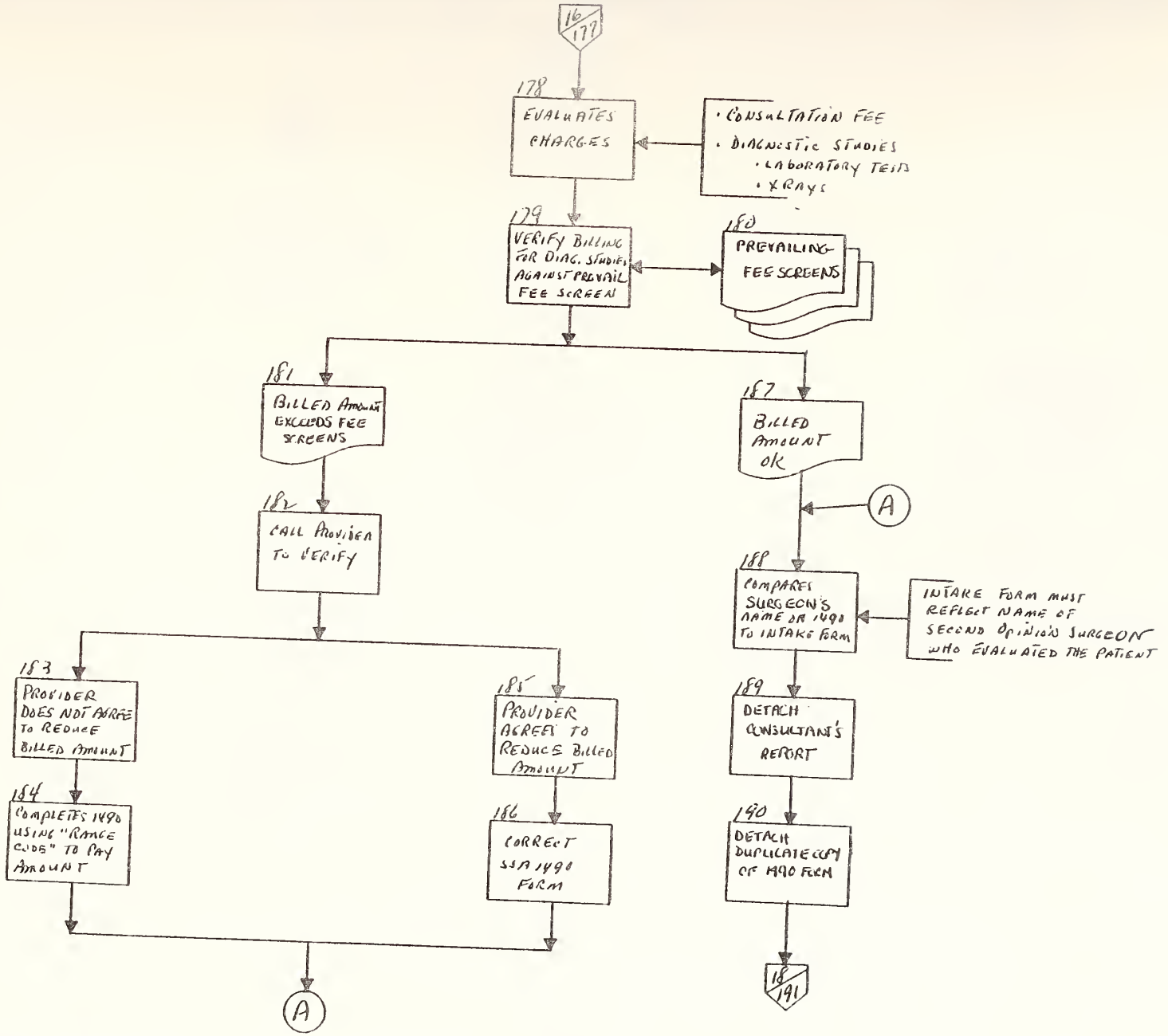


MEDICARE SECOND SURGICAL OPINION EXPERIMENTAL PROGRAM DATE 3/30/78

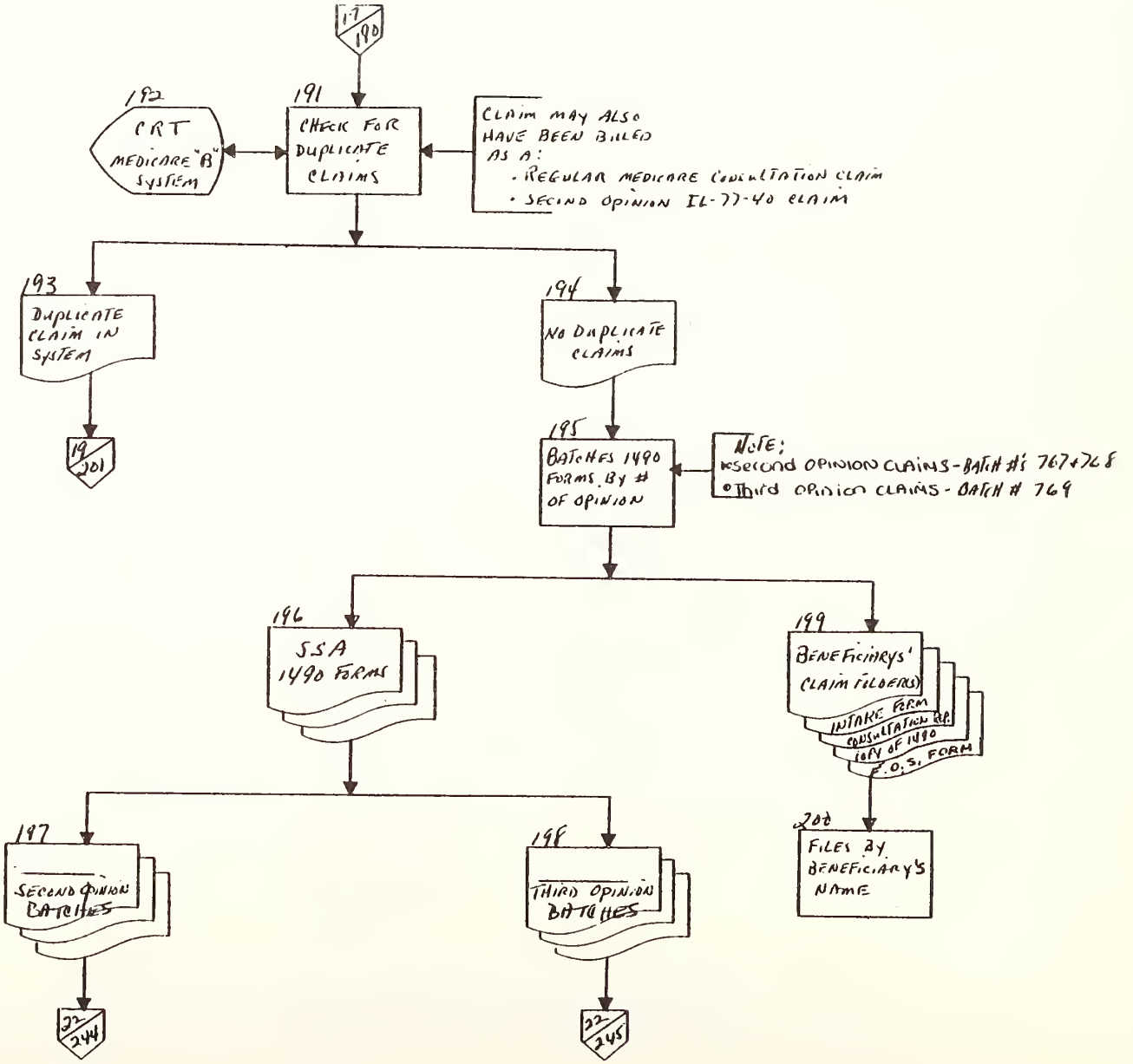

13/151
153
PROCESSES FOR MEDICARE STATUS QUERY
154
BENEFICIARY'S FILE FOLDER
152
SSA 1490 FORMS
8/84
155
HOLDS AWAITING STATUS QUERY RESPONSE
158
SSA 1490 FORMS
157
ROUTES TO CONTROL CLERK
4/28
159
MATCHES SSA 1490 TO BENE. FILE FOLDER
15/160

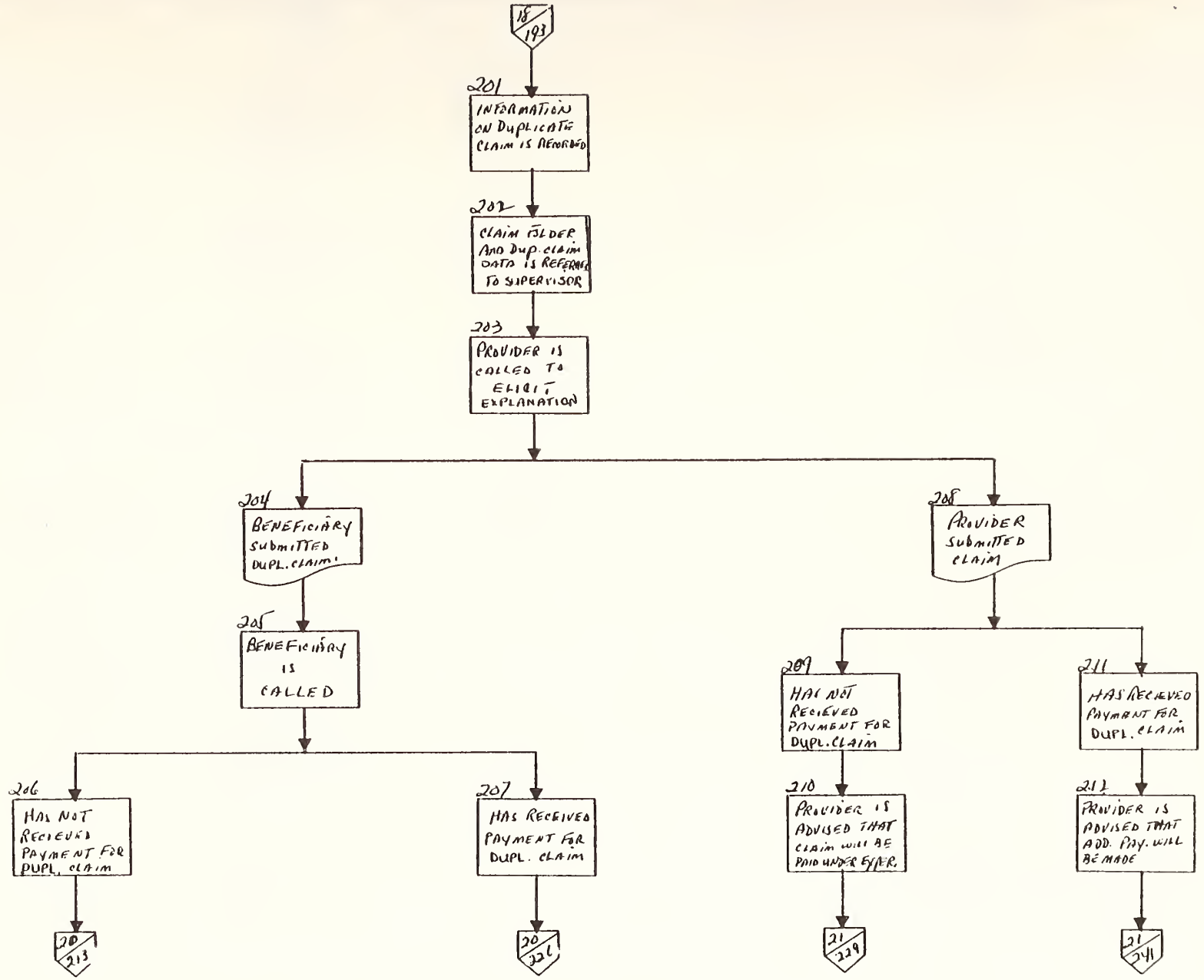

14/159
13/157
160
SSA 1491 FORMS + BENE. FOLDERS
CONSULTANT REPORT
NOTE:
STEPS 161-168 DO NOT APPLY TO CLAIMS SUBMITTED BY LABORATORIES
161
REVIEWS CONSULTANT REPORT FOR COMPLETENESS
162
INCOMPLETE
167
COMPLETE
A
168
REVIEWS SSA 1490 FOR COMPLETENESS
163
RETURNS TO SURGEON WITH NOTE
165
PHONES PROVIDER
169
DISCREPANCIES FOLLOW STEPS 163-166
164
FORM CORRECTED AND RETURNED TO SSRC
166
OBTAINS MISSING DATA
16/170
A

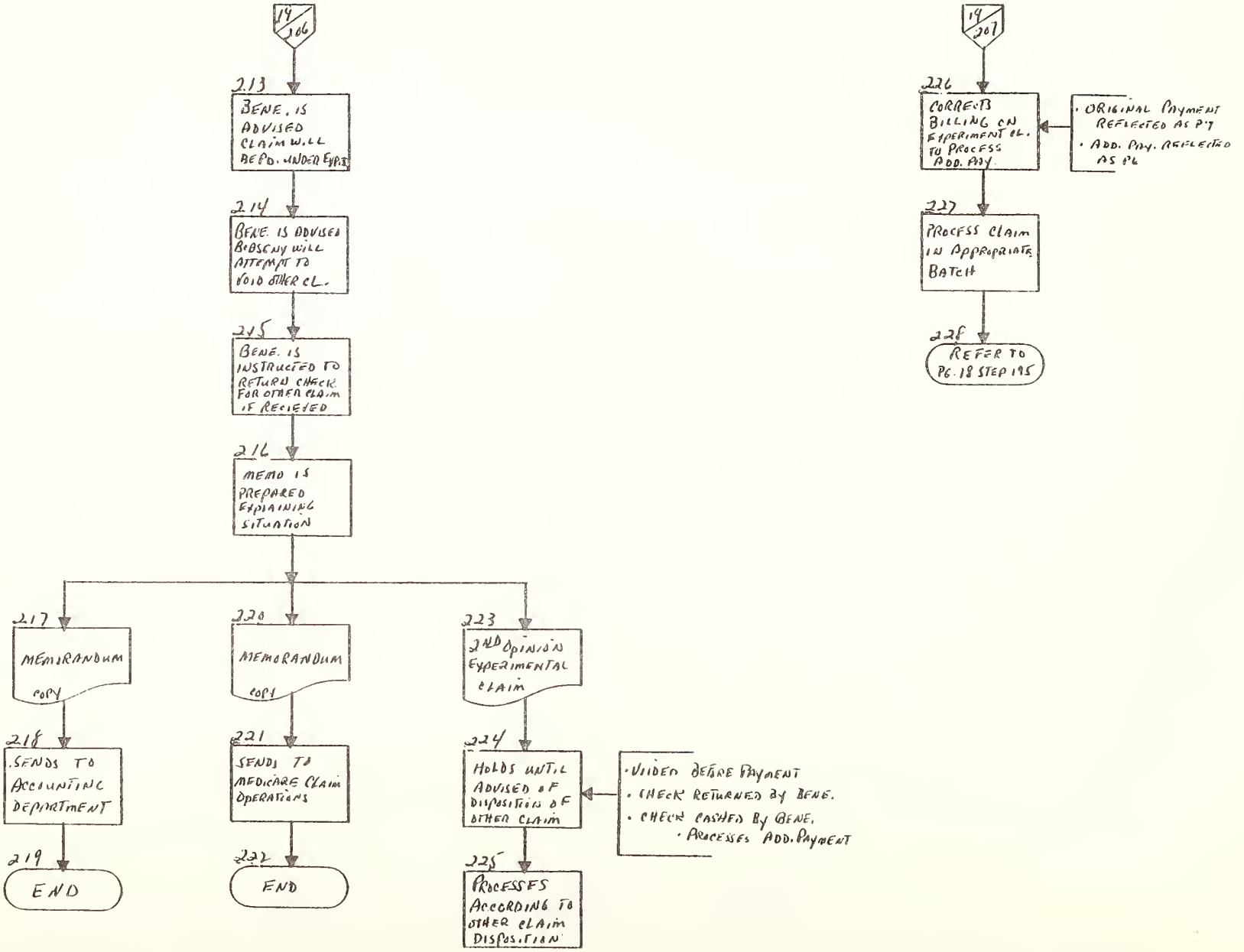

15/169
170
REVIEW SSA 1490 FORM
171
EVALUATE SERVICES WITH DIAGNOSIS
172
SERVICES INCONSISTENT WITH DIAGNOSIS
173
PHONES PROVIDER
174
SERVICES PERFORMED
175
SERVICES BILLED IN ERROR ARE CORRECTED
176
SERVICES CONSISTENT WITH DIAGNOSIS
A
177
CODES:
· PROCEDURE
· TYPE OF SERV.
17/178
A

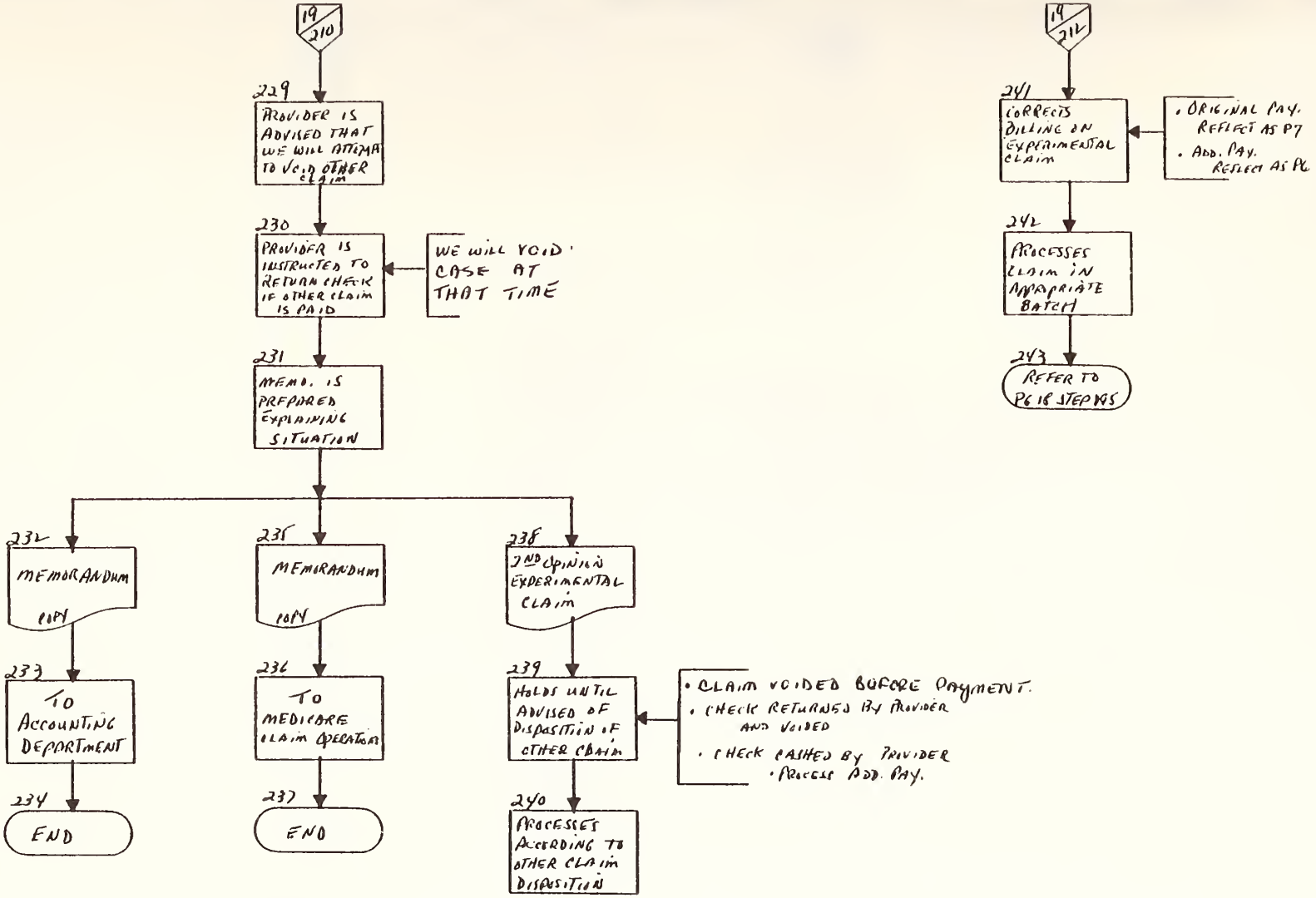


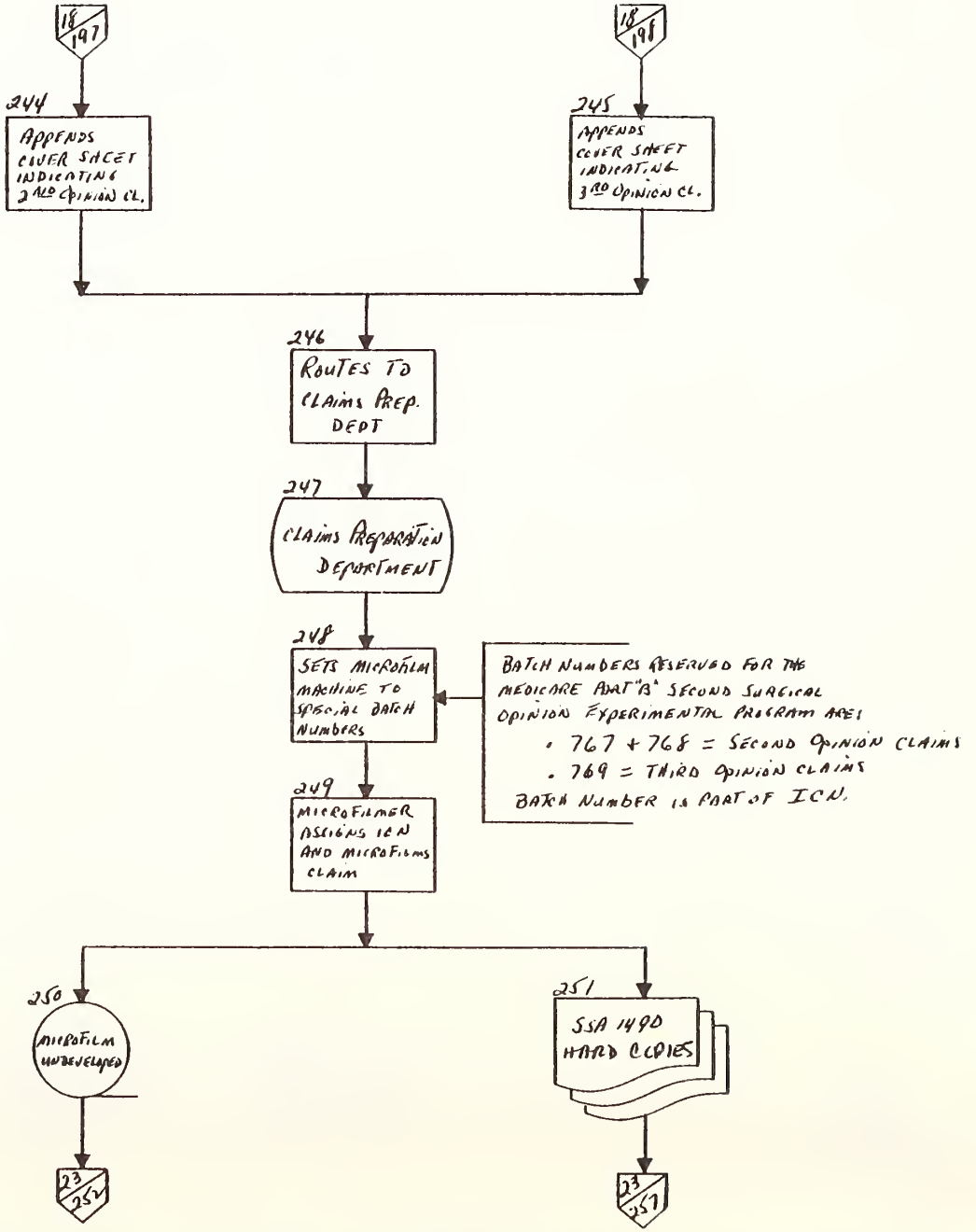
MEDICARE SECOND SURGICAL OPINION EXPERIMENTAL DIAGRAM DATE 3/24/78

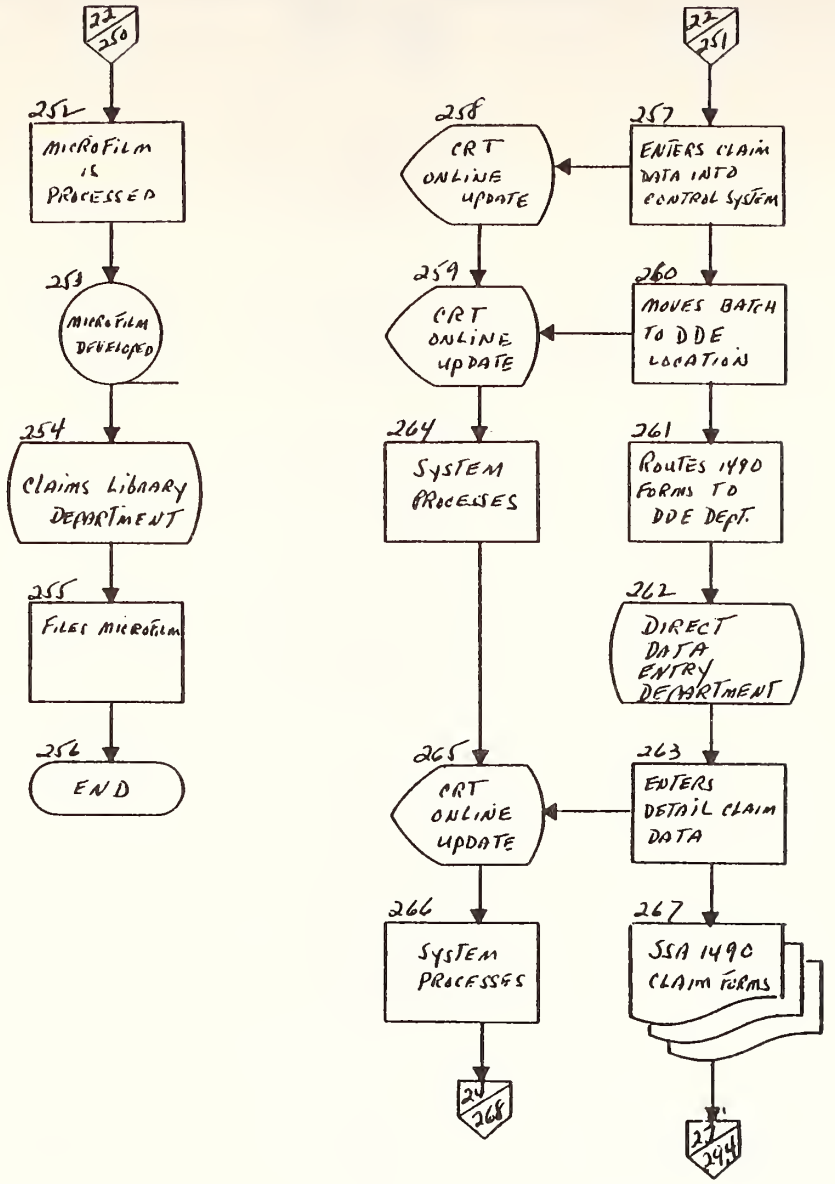

1-7 / 190
191
CHECK FOR DUPLICATE CLAIMS
192
CRT MEDICARE "B" SYSTEM
CLAIM MAY ALSO HAVE BEEN BILLED AS A:
• REGULAR MEDICARE CONSULTATION CLAIM
• SECOND OPINION IL-77-40 CLAIM
193
DUPLICATE CLAIM IN SYSTEM
19 / 201
194
NO DUPLICATE CLAIMS
195
BATCHES 1490 FORMS BY # OF OPINION
NOTE:
•SECOND OPINION CLAIMS - BATCH #'S 767+768
•THIRD OPINION CLAIMS - BATCH # 769
196
SSA 1490 FORMS
199
BENEFICIARYS' CLAIM FOLDERS
INTAKE FORM
CONSULTATION RP
COPY OF 1490
E.O.S. FORM
200
FILES BY BENEFICIARY'S NAME
197
SECOND OPINION BATCHES
22 / 244
198
THIRD OPINION BATCHES
22 / 245

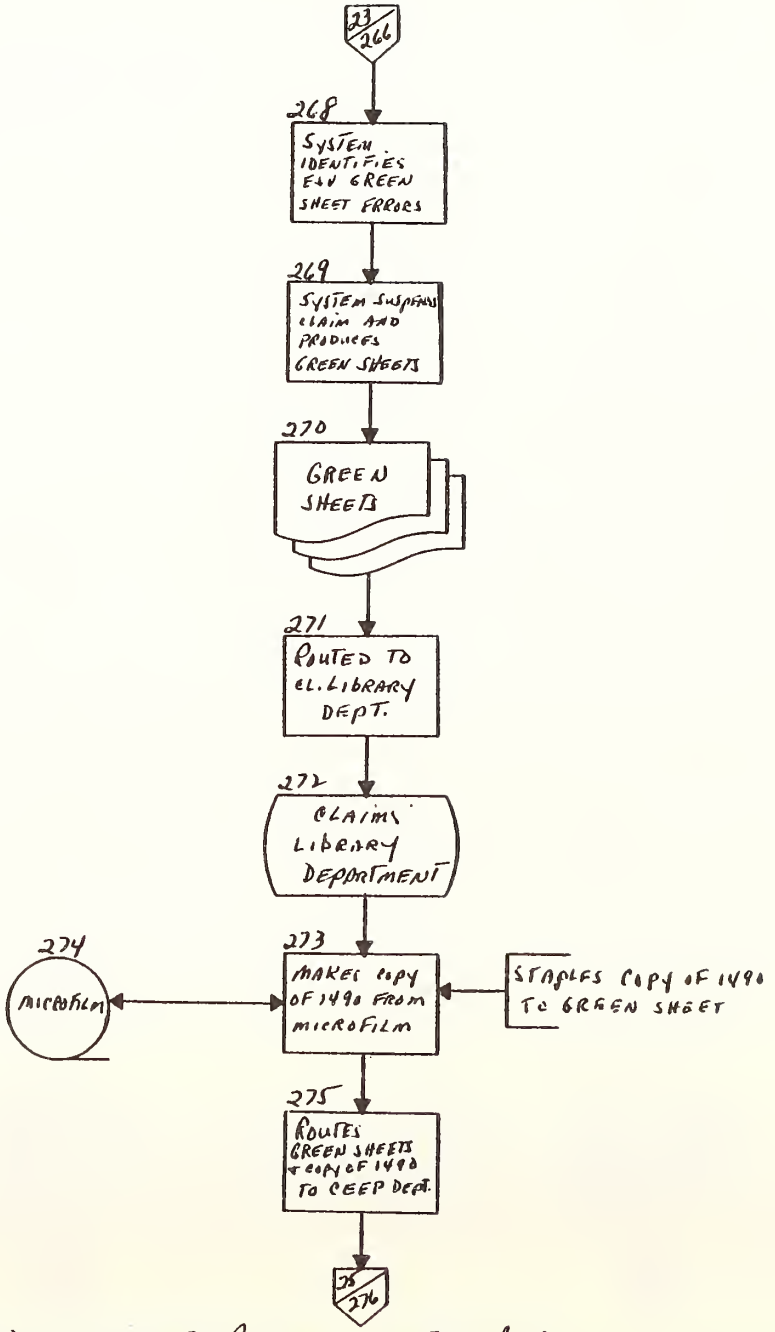

18/193
201
INFORMATION ON DUPLICATE CLAIM IS RECORDED
202
CLAIM FOLDER AND DUP. CLAIM DATA IS REFERRED TO SUPERVISOR
203
PROVIDER IS CALLED TO ELICIT EXPLANATION
204
BENEFICIARY SUBMITTED DUPL. CLAIM
205
BENEFICIARY IS CALLED
206
HAS NOT RECIEVED PAYMENT FOR DUPL. CLAIM
20/213
207
HAS RECEIVED PAYMENT FOR DUPL. CLAIM
20/326
208
PROVIDER SUBMITTED CLAIM
209
HAS NOT RECIEVED PAYMENT FOR DUPL. CLAIM
210
PROVIDER IS ADVISED THAT CLAIM WILL BE PAID UNDER EXPER.
21/229
211
HAS RECIEVED PAYMENT FOR DUPL. CLAIM
212
PROVIDER IS ADVISED THAT ADD. PAY. WILL BE MADE
21/241

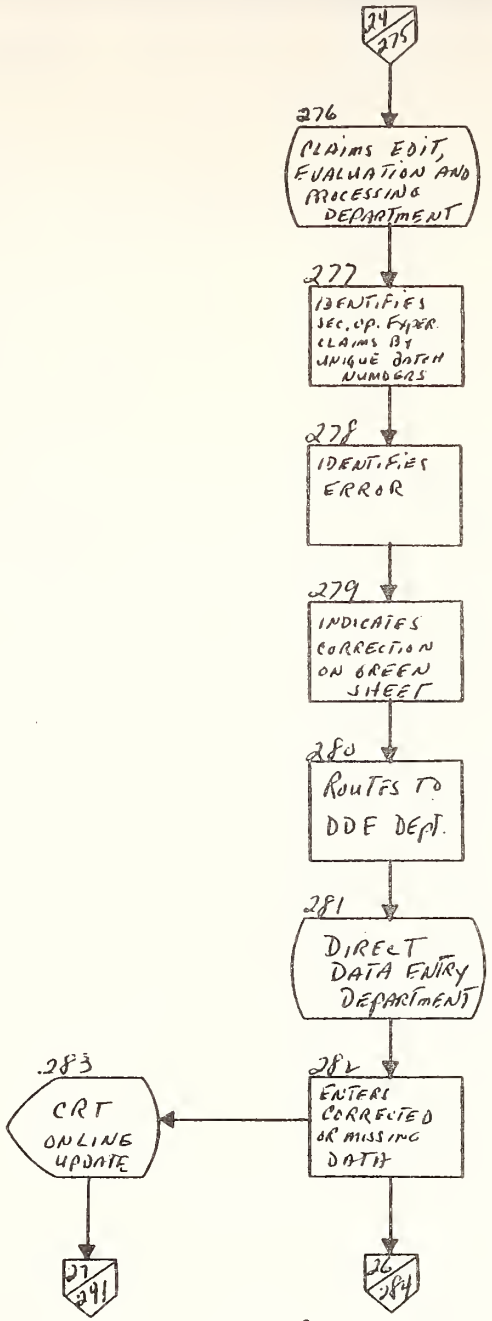

19/206
213
BENE. IS ADVISED CLAIM WILL BE PD. UNDER EXP.
214
BENE. IS ADVISED BOBSENY WILL ATTEMPT TO VOID OTHER CL.
215
BENE. IS INSTRUCTED TO RETURN CHECK FOR OTHER CLAIM IF RECIEVED
216
MEMO IS PREPARED EXPLAINING SITUATION
217
MEMORANDUM COPY
218
SENDS TO ACCOUNTING DEPARTMENT
219
END
220
MEMORANDUM COPY
221
SENDS TO MEDICARE CLAIM OPERATIONS
222
END
223
2ND OPINION EXPERIMENTAL CLAIM
224
HOLDS UNTIL ADVISED OF DISPOSITION OF OTHER CLAIM
• VOIDED BEFORE PAYMENT
• CHECK RETURNED BY BENE.
• CHECK CASHED BY BENE. • PROCESSES ADD. PAYMENT
225
PROCESSES ACCORDING TO OTHER CLAIM DISPOS. FIAN
19/207
226
CORRECTS BILLING ON EXPERIMENT CL. TO PROCESS ADD. PAY.
• ORIGINAL PAYMENT REFLECTED AS P.T
• ADD. PAY. REFLECTED AS PL
227
PROCESS CLAIM IN APPROPRIATE BATCH
228
REFER TO PG. 18 STEP 195

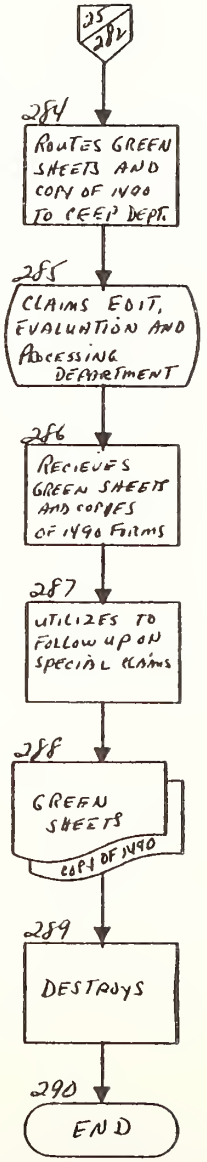

19/210
229
PROVIDER IS ADVISED THAT WE WILL ATTEMPT TO VOID OTHER CLAIM
230
PROVIDER IS INSTRUCTED TO RETURN CHECK IF OTHER CLAIM IS PAID
WE WILL VOID CASE AT THAT TIME
231
MEMO. IS PREPARED EXPLAINING SITUATION
232
MEMORANDUM COPY
233
TO ACCOUNTING DEPARTMENT
234
END
235
MEMORANDUM COPY
236
TO MEDICARE CLAIM OPERATION
237
END
238
2ND OPINION EXPERIMENTAL CLAIM
239
HOLDS UNTIL ADVISED OF DISPOSITION OF OTHER CLAIM
• CLAIM VOIDED BEFORE PAYMENT.
• CHECK RETURNED BY PROVIDER AND VOIDED
• CHECK CASHED BY PROVIDER • PROCESS ADD. PAY.
240
PROCESSES ACCORDING TO OTHER CLAIM DISPOSITION
19/241
241
CORRECTS BILLING ON EXPERIMENTAL CLAIM
• ORIGINAL PAY. REFLECT AS P7
• ADD. PAY. REFLECT AS P6
242
PROCESSES CLAIM IN APPROPRIATE BATCH
243
REFER TO P6 IB STEPMS

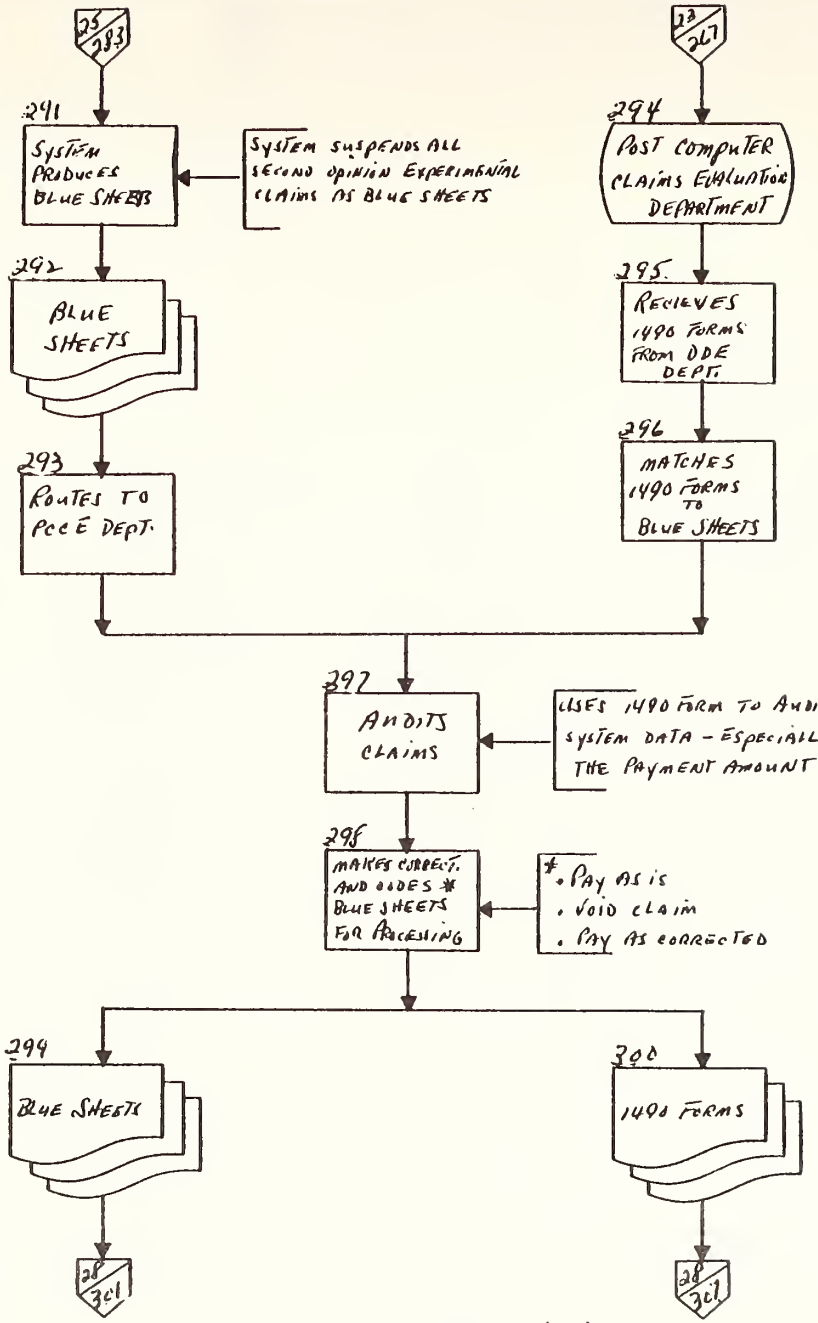

18/197
18/196
244
APPENDS COVER SHEET INDICATING 2ND OPINION CL.
245
APPENDS COVER SHEET INDICATING 3RD OPINION CL.
246
ROUTES TO CLAIMS PREP. DEPT
247
CLAIMS PREPARATION DEPARTMENT
248
SETS MICROFILM MACHINE TO SPECIAL BATCH NUMBERS
BATCH NUMBERS RESERVED FOR THE MEDICARE PART "B" SECOND SURGICAL OPINION EXPERIMENTAL PROGRAM ARE:
• 767 + 768 = SECOND OPINION CLAIMS
• 769 = THIRD OPINION CLAIMS
BATCH NUMBER IS PART OF ICN.
249
MICROFILMER ASSIGNS ICN AND MICROFILMS CLAIM
250
MICROFILM UNDEVELOPED
251
SSA 1490 HARD COPIES
23/254
23/257


22/250
252
MICROFILM IS PROCESSED
253
MICROFILM DEVELOPED
254
CLAIMS LIBRARY DEPARTMENT
255
FILES MICROFILM
256
END
22/251
257
ENTERS CLAIM DATA INTO CONTROL SYSTEM
258
CRT ONLINE UPDATE
259
CRT ONLINE UPDATE
260
MOVES BATCH TO DDE LOCATION
261
ROUTES 1490 FORMS TO DDE DEPT.
262
DIRECT DATA ENTRY DEPARTMENT
263
ENTERS DETAIL CLAIM DATA
264
SYSTEM PROCESSES
265
CRT ONLINE UPDATE
266
SYSTEM PROCESSES
267
SSA 1490 CLAIM FORMS
24/268
22/244

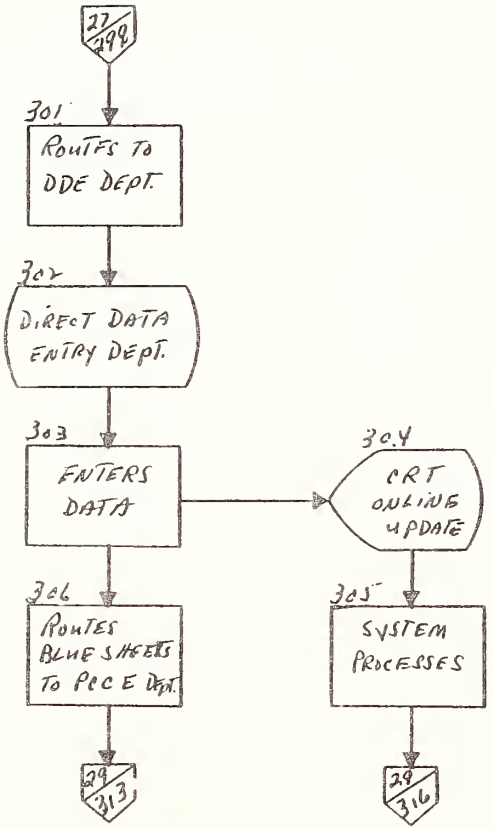

23/266
268
SYSTEM IDENTIFIES E&M GREEN SHEET ERRORS
269
SYSTEM SUSPENDS CLAIM AND PRODUCES GREEN SHEETS
270
GREEN SHEETS
271
ROUTED TO EL. LIBRARY DEPT.
272
CLAIMS LIBRARY DEPARTMENT
273
MAKES COPY OF 1490 FROM MICROFILM
274
MICROFILM
STAPLES COPY OF 1490 TO GREEN SHEET
275
ROUTES GREEN SHEETS + COPY OF 1490 TO CEEP DEPT.
25/276

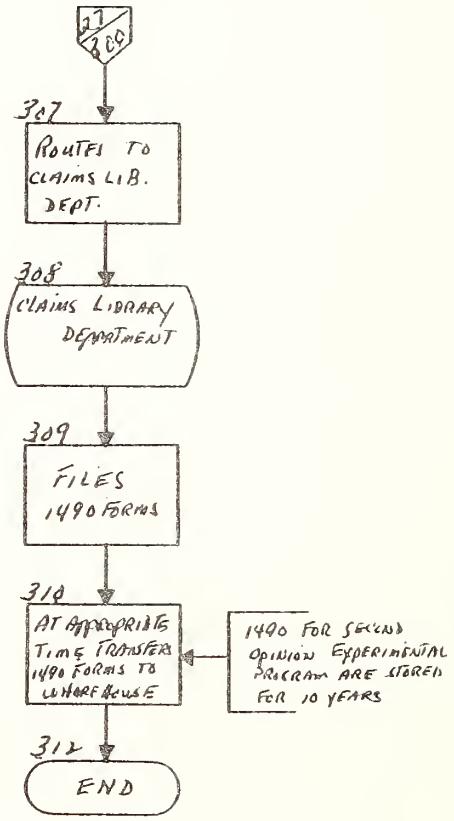

24/275
276
CLAIMS EDIT, EVALUATION AND PROCESSING DEPARTMENT
277
IDENTIFIES SEC. OP. FYER. CLAIMS BY UNIQUE BATCH NUMBERS
278
IDENTIFIES ERROR
279
INDICATES CORRECTION ON GREEN SHEET
280
ROUTES TO DDE DEPT.
281
DIRECT DATA ENTRY DEPARTMENT
282
ENTERS CORRECTED OR MISSING DATA
283
CRT ONLINE UPDATE
27/291
26/284

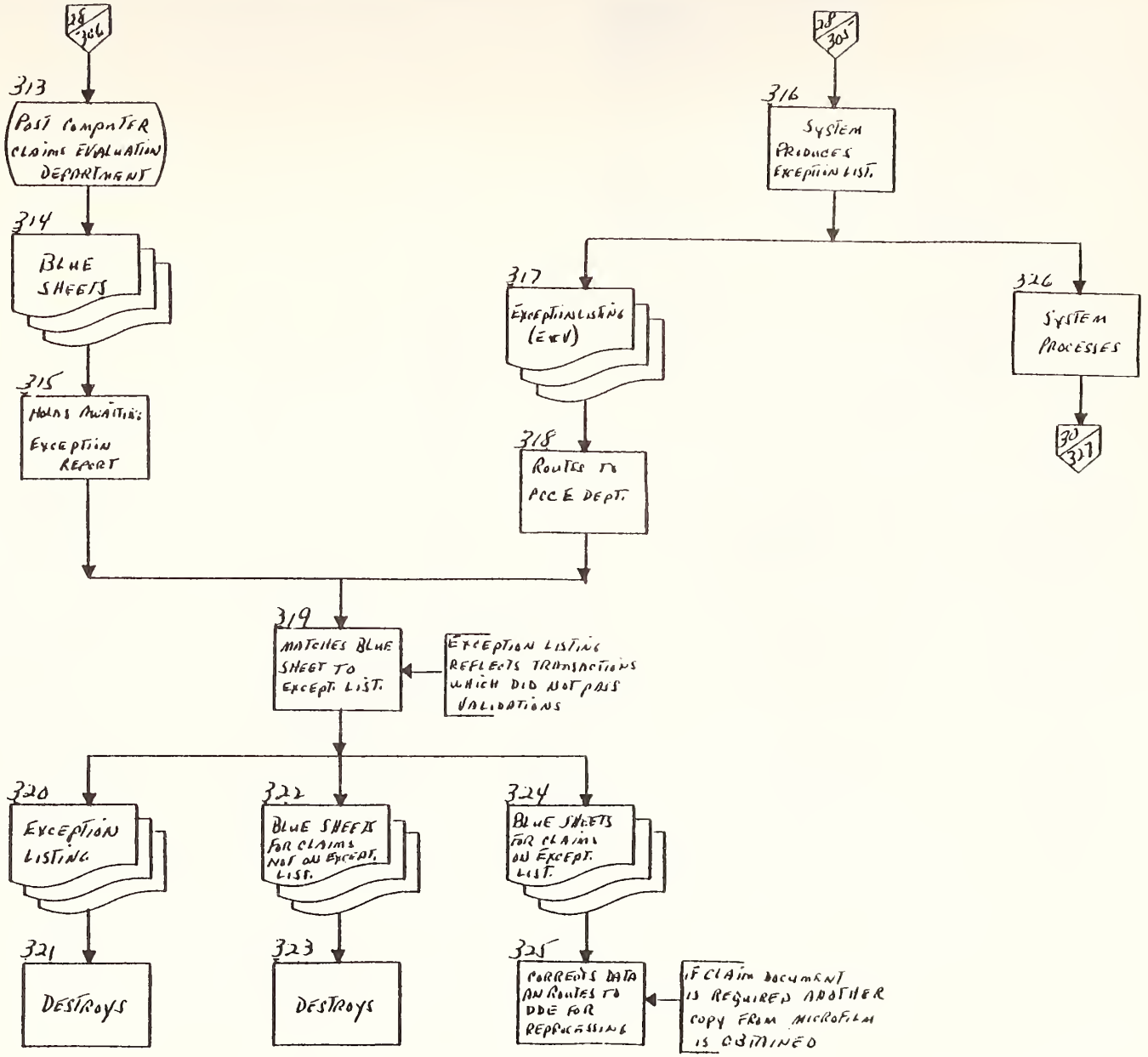

25
28V
284
ROUTES GREEN SHEETS AND COPY OF 1490 TO CEEP DEPT.
285
CLAIMS EDIT, EVALUATION AND PROCESSING DEPARTMENT
286
RECIEVES GREEN SHEETS AND COPIES OF 1490 FORMS
287
UTILIZES TO FOLLOW UP ON SPECIAL CLAIMS
288
GREEN SHEETS
COPY OF 1490
289
DESTROYS
290
END

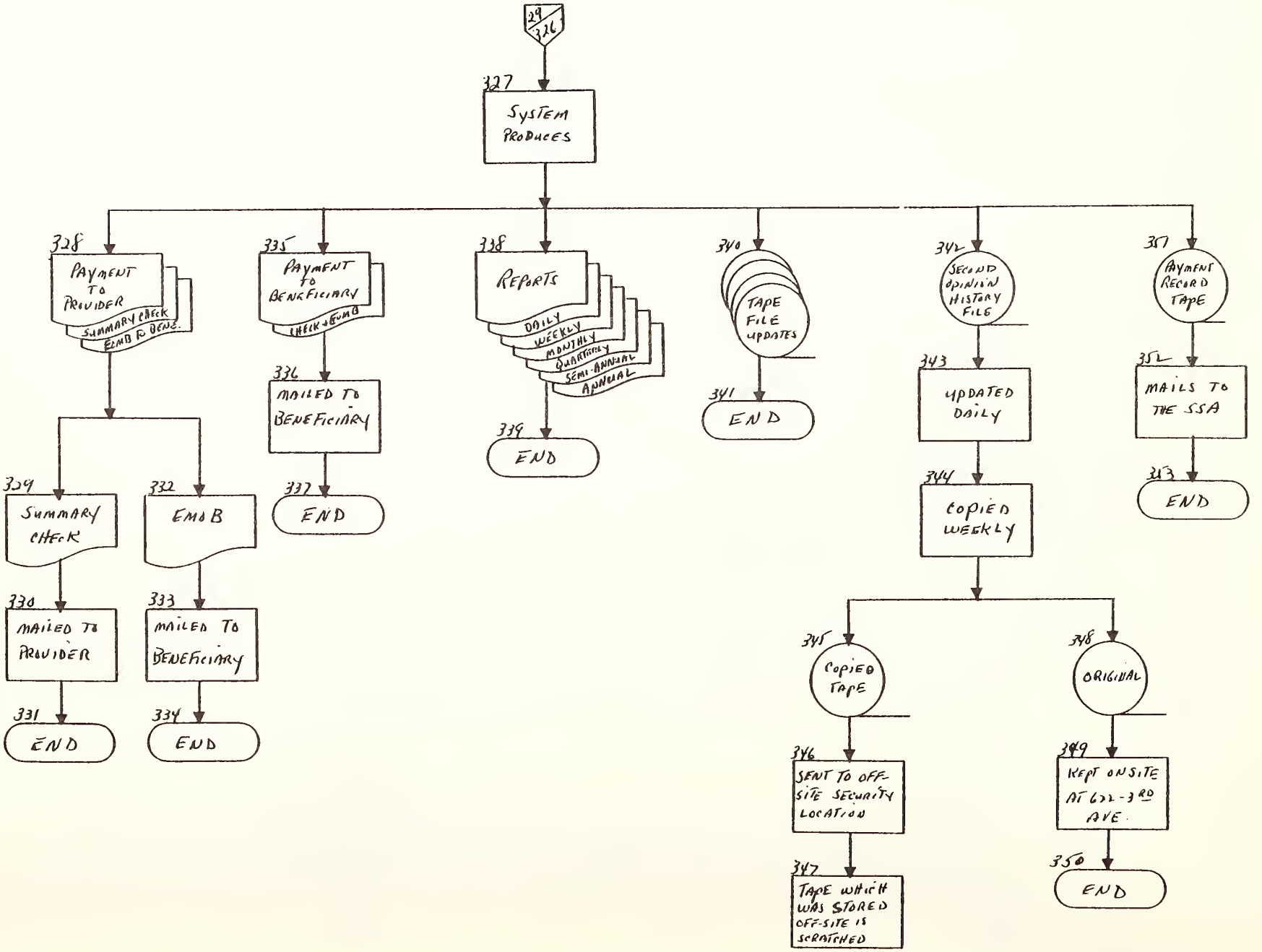

25/283
23/267
291
System Produces Blue Sheets
System suspends all second opinion experimental claims as blue sheets
294
Post computer claims evaluation department
292
Blue sheets
295
Recieves 1490 forms from DDE dept.
293
Routes to PCCE dept.
296
Matches 1490 forms to Blue sheets
297
Audits claims
Uses 1490 form to audit system data - especially the payment amount
298
Makes correct. and codes * Blue sheets for processing
* • Pay as is
• Void claim
• Pay as corrected
299
Blue sheets
300
1490 forms
28/301
28/301

DATE 3/30/78


27/299
301
ROUTES TO DDE DEPT.
302
DIRECT DATA ENTRY DEPT.
303
ENTERS DATA
304
CRT ONLINE UPDATE
305
SYSTEM PROCESSES
306
ROUTES BLUE SHEETS TO PEC E DEPT.
29/313
29/316


27/300
307
ROUTES TO CLAIMS LIB. DEPT.
308
CLAIMS LIBRARY DEPARTMENT
309
FILES 1490 FORMS
310
AT APPROPRIATE TIME TRANSFER 1490 FORMS TO WAREHOUSE
1490 FOR SECOND OPINION EXPERIMENTAL PROGRAM ARE STORED FOR 10 YEARS
312
END


28/306
313
POST COMPUTER CLAIMS EVALUATION DEPARTMENT
314
BLUE SHEETS
315
HOLDS AWAITING EXCEPTION REPORT
28/305
316
SYSTEM PRODUCES EXCEPTION LIST.
317
EXCEPTION LISTING (EXCL)
318
ROUTES TO PCC E DEPT.
326
SYSTEM PROCESSES
30/327
319
MATCHES BLUE SHEET TO EXCEPT. LIST.
EXCEPTION LISTING REFLECTS TRANSACTIONS WHICH DID NOT PASS VALIDATIONS
320
EXCEPTION LISTING
322
BLUE SHEETS FOR CLAIMS NOT ON EXCEPT. LIST.
324
BLUE SHEETS FOR CLAIMS ON EXCEPT. LIST.
321
DESTROYS
323
DESTROYS
325
CORRECTS DATA AND ROUTES TO DDE FOR REPROCESSING
IF CLAIM DOCUMENT IS REQUIRED ANOTHER COPY FROM MICROFILM IS OBTAINED


29/326
327
SYSTEM PRODUCES
328
PAYMENT TO PROVIDER
SUMMARY CHECK
EMOB & BENE.
329
SUMMARY CHECK
330
MAILED TO PROVIDER
331
END
332
EMOB
333
MAILED TO BENEFICIARY
334
END
335
PAYMENT TO BENEFICIARY
CHECK & EMOB
336
MAILED TO BENEFICIARY
337
END
338
REPORTS
DAILY
WEEKLY
MONTHLY
QUARTERLY
SEMI-ANNUAL
ANNUAL
339
END
340
TAPE FILE UPDATES
341
END
342
SECOND OPINION HISTORY FILE
343
UPDATED DAILY
344
COPIED WEEKLY
345
COPIED TAPE
346
SENT TO OFF-SITE SECURITY LOCATION
347
TAPE WHICH WAS STORED OFF-SITE IS SCRATCHED
348
ORIGINAL
349
KEPT ONSITE AT 622-3RD AVE
350
END
351
PAYMENT RECORD TAPE
352
MAILS TO THE SSA
353
END

POLICIES AND PROCEDURES

BAD DEBTS

We have discussed with the Regional Office how to handle the problem of a Beneficiary's Part B eligibility lapsing between the time a second opinion is requested and a claim form is received by the Referral Center.

It is anticipated that the possibility of this occurring is highly unlikely, because of the rather lenient "grace periods" applied to Part B premium payments. However, as a precaution should the occasion arise, the reimbursement system was explored.

Despite the experimental nature of this Demonstration Program and the incentive of "no out-of-pocket costs" for the Beneficiary, we have no mechanism to reimburse for services provided to an ineligible Beneficiary. While the Contractor's existing Medicare System could process the payment, Baltimore's system will identify the case as ineligible and return it as a payment error.

We recognize, however, that in essence, by referring the Beneficiary to the Second Opinion Surgeon we have done so with the understanding that we would reimburse him for his services.

Therefore, in an effort to maintain our reimbursement commitment to Panel physicians, it has been agreed that:

° The Regional Office of the Medicare Bureau will be advised should a "bad debt" occur.

° The case will be handled individually.

CROSSING OF SPECIALTIES

In the past, every effort has been made to refer eligible patients to surgeons in the same specialty/subspecialty as their first surgeon.

There are, however, occasions when:

° The patient wishes to see a surgeon of a different specialty, i.e., a neurosurgeon for a herniated disc rather than a second orthopedic surgeon, and

° The analyst, in discussion with the Referral Center supervisor, feels that the interests of the patient could best be served if he were referred to a surgeon representing a specialty which is more closely aligned to the patient's symptoms or diagnosis.

In these rare instances cited above, it has been our practice in the past to accommodate both of these situations by "crossing surgical specialties" and providing the patient with the names of three (3) surgeons in a specialty different from that of the first surgeon.

Unless we are advised to the contrary, we will continue this practice. For identification purposes, a distinguishing mark will be placed on the folders and consultant reports of all cases falling into this category should the Evaluator wish to segregate them at some later date.

DUPLICATE CLAIMS

(In The Contractor's Carrier Area)

Immediately prior to releasing an Experimental Claim for payment processing, the CRT will be utilized by the Control Clerk to verify that the Second Opinion Service has not been additionally billed under the Routine Benefit by the Provider or Beneficiary.

If a duplicate claim is identified;

- the Referral Center will contact Medicare Claims Operations and request that they void the claim before payment;
- if this can be accomplished, the Provider or Beneficiary will be informed that the Routine Claim is being voided and the Experimental Claim will be processed, and;
- the Experimental Claim will be processed for the total payment.

If voiding of the payment cannot be accomplished;

- an Experimental Claim will be processed to subsidize the Beneficiary for the amount unpaid under the Routine Benefit. This is necessary because;
  1. all of the covered charges had to be applied to the Beneficiary's deductible;
  2. part of the covered charges were used to satisfy the deductible and the Beneficiary had to pay the coinsurance amount;
  3. the deductible had been met previously and the Beneficiary had to pay the coinsurance amount.

The following mechanism is used for this reimbursement procedure:

- A new Second Opinion Experimental Program Claim is set up and processed.
  - In those situations where a partial payment was made on the original claim, that data will be recorded on the Experimental Program Claim "for informational purposes only".
  - This is accomplished by coding the line item as a "P7" Action Code.

° The amount to be paid is coded as a "P6" Action Code. Under this approach, the Beneficiary receives an additional payment to subsidize the out-of-pocket expenses and the Second Opinion Experimental Program's Claim History reflects the total payment on the claim.

For example:

° Assume the Beneficiary incurred a $50.00 charge and was paid $40.00 under the Regular Medicare Second Opinion Program. Under the Experimental Program, payment would be $50.00. Therefore, an additional $10.00 is owed.

° Part II of the SSA 1490 form will be completed as follows:

Action Code	Procedure	Code	Charges	
7	Consultation	9-9054	$40.00	
6	Consultation	9-9054	$10.00	
			$50.00	Total Charges
			$10.00	- additional payment.

This mechanism is described more fully on page under Reimbursement for Services Billed On A SSA 1483.

DUPLICATE CLAIMS

(In GHI's Carrier Area)

On a monthly basis, xeroxed copies of Experimental SSA 1490 Claims from Queens' Providers will be sent to Group Health Incorporated.

It is anticipated that on a quarterly basis, GHI will check these Experimental Claims against their payment records for possible duplicate claims.

It is believed that checking for duplicate claims within a shorter period would not allow adequate time for this contingency to be recognized, as the duplicate bills may not have yet been submitted for processing.

If a duplicate bill is identified, the Carrier will notify the Contractor and we will handle the situation as we would if the duplicate claim were received in house and could not have been voided before payment.

ESTABLISHING ELIGIBILITY

Resources

° Cathode Ray Tube (CRT) provides eligibility status of:

All Part B Beneficiaries who have incurred a claim with the Carrier during the last three (3) months.

° Best File

Reflects the eligibility status of all Beneficiaries residing in New York State.

° BCBSGNY Model "A" System status query:

Provides eligibility status from Baltimore within a minimum of three (3) days turn around time.

Status Queries

Submission of Status Queries to Baltimore is routinely performed by the automated Processing System. Due to its exclusion in the Experimental Program Systems Modifications, the function must be performed manually.

Since a status query verifying Medicare Part B eligibility must be sent by the Referral Center on all Beneficiaries prior to releasing an approved Experimental SSA 1490 for payment, consideration has been given to employing this mechanism for all Beneficiaries at the time they register with the Center.

Its primary disadvantage, however, is the turn around time, which may be extended if Baltimore has difficulty locating the Beneficiary's record, or if there are computer delays. This means that:

° The Beneficiary could not proceed with the Second Opinion until eligibility notification is received.

° An additional telephone call has to be made to the Beneficiary after eligibility is established.

° There is potential for discouraging Beneficiaries in the use of the benefit.

Therefore, it has been determined that the eligibility establishing priority mechanism will be as follows:

- The CRT claims history will be checked. If no information is available, the analyst will:
  - Check the Best File. If no information is obtained, the analyst will then proceed with a status query.

Advantages:

- Employing the CRT, we can establish eligibility immediately.
- With the Best File we can get back to the Beneficiary the same day.

It is our expectation that eligibility:

- On more than 50% of the applicants will be initially established via the CRT.
- On the bulk of the remaining population will be initially established via the Best File.

On a temporary basis, the Status Query will be sent on all cases to verify eligibility after it has been initially established via the CRT or Best File.

While this will be our planned procedure, we request the right to amend it based on our experience. If, at a later date, it is found that this query serves no purpose, we will suggest eliminating it on these above cases.

However, the Status Query will continue to be used whenever eligibility cannot initially be established via the above methods. Beneficiaries falling into this category will not be provided with the surgeons names until eligibility is confirmed with Baltimore.

EXCLUSIONS

Some services are specifically excluded under Title XVIII of the Social Security Act, Section 1862.

- Expenses for cosmetic surgery, the removal of teeth in the absence of underlying medical problems which would require hospitalization for these extractions, and routine foot care including cutting or removal of corns, warts or calluses, represent some examples.

Second opinions requested for these procedures will have to be denied on the basis that the service itself is specifically excluded from coverage under the Medicare statutes.

Other services may be non covered because they are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. This is a general statutory exclusion from Medicare coverage. Because the patient may not know in advance whether the surgery being considered is reasonable and necessary, we have been advised by HCFA that reimbursement will be made for a second opinion, even if it is later determined that the surgery itself was not reasonable and necessary.

IN-HOSPITAL REFERRALS

Occasionally, a patient will be hospitalized for a medical problem or a diagnostic work up that requires institutionalization. After a period of treatment and/or performance of studies, a diagnosis may be made that warrants elective surgical intervention.

According to our policies, individuals falling into this category would be eligible for a second opinion.

After eligibility is established, the following procedure is employed:

- A surgeon must be found who:
  - is on the Panel;
  - has priviledges in the particular hospital in which the patient is institutionalized;
  - is of the same surgical specialty/subspecialty as the First Opinion Surgeon;
  - is available to make the in-hospital consultation, and;
  - is willing to accept the same fee as agreed upon for office consultations.

If found:

- The patient is notified.
- The primary physician is informed of the consultant's visit. *
- Appropriate forms are mailed directly to the Second Opinion Surgeon.

This procedure is not without its difficulties. They include:

- Physician Related
  - Locating a Panel physician of the appropriate discipline who has staff priviledges in the hospital in question.
  - Arranging for the consultation before surgery is scheduled.

* Hospitalized Beneficiaries will be advised at the time of their initial call to the Center, that confidentiality relative to the consultation cannot be accomplished because of the very nature of hospital practice and administrative procedures.

- Patient Related
  - The potential of patients discharging themselves against medical orders so as to be able to obtain access to the Benefit, should no Panel surgeons be affiliated with the hospital.
  - The potential of others choosing to undergo the surgery without input of a second opinion, yet criticizing the Contractor for advertising a cost free benefit to which they cannot gain access.

The Contractor has no answers to these problems. We recognize their existence and express concern regarding their potential frequency, particularly and primarily, if the best interests of the patient are not served.

In all instances, the Beneficiary and/or his family must make the decision in terms of how to proceed if no Panel consultants are available.

Statistics will be kept of this situation in terms of the number of Beneficiaries for whom these consultations cannot be arranged.

PRE-SELECTION OF A SECOND OPINION SURGEON

If a Beneficiary calls the Referral Center specifically requesting to see a surgeon who is on our Panel, the Beneficiary may do so providing:

- he meets all eligibility criteria, and;
- he clearly understands the Cooperating Physician Agreement, especially as it relates to the Second Opinion Surgeon not performing surgery or otherwise treating him.

UTILIZATION OF PANEL SURGEONS

In order to identify early in the Experiment, whether any particular surgeon(s) is being utilized extensively for second opinions, a separate profile sheet for each cooperating surgeon will be maintained.

Daily entries on these sheets will reflect the number of patients seen by each surgeon over any given period of time.

With these statistics readily available, the Evaluator would be able to:

- determine if an adequate sample of opinions was being obtained, and;
- whether reexamination of our referral activities is indicated.

PROGRAM RELATED INQUIRIES

Despite the underlying value of centralization of Program activities, it is unrealistic to assume, given the limited number of open telephone lines, and staff, that the Referral Center could respond efficiently and promptly to all inquiries and requests regarding the Experiment, without the support and assistance of Medicare Service Areas.

Additionally, we anticipate increased Beneficiary inquiries as a result of the two Second Opinion Benefits being concurrently encouraged; each with different eligibility criteria and reimbursement mechanisms.

All of our educational and advertising campaigns specifically cite the Referral Center telephone number and post office box. However, from past experience, we know that calls and correspondence will be directed to Service Areas.

Subsequently, in an effort to integrate the activities of all areas responding to Beneficiaries inquiries, the following arrangements have been made;

- Inquiries received by the Beneficiary Correspondence Department will be handled in the following manner:
  - if they relate to general information regarding the Experiment, the Correspondence area will send a cover letter and brochure to the Beneficiary. Until the brochures are available for distribution, a letter explaining the benefit will be sent;
  - if they relate to specific details of the Experiment, i.e., requesting the names of Panel physicians, the inquiry will be forwarded to the Referral Center.
- Inquiries received by the Beneficiary Telephone Area and Beneficiary Interview Center will be handled as described above.
- The Beneficiary will be directed to the Referral Center for a response whenever the inquiry;
  - requires exceptionally technical input for a response or;
  - involves an individual who is already a client of the Second Opinion Program.
- Inquiries received by the Provider Service and Physicians Telephone Areas regarding the Experimental Program will be rereferred to the Referral Center.

Blue Cross
Blue Shield
of Greater New York

MEDICARE

622 Third Avenue, New York, N.Y. 10017

Dear Beneficiary:

Thank you for your inquiry regarding second opinions under Medicare.

As of May 22nd, 1978, the Federal Government will be making available a new benefit as part of a 3 year study project.

This benefit will provide you with a second opinion by a board certified surgical specialist at no cost to you. To be eligible you must have Part B Medicare as well as reside in one of the following counties:

Bronx	Dutchess	Nassau	Putnam	Rockland	Ulster
Columbia	Greene	New York	Queens	Suffolk	Westchester
Delaware	Kings	Orange	Richmond	Sullivan	

One of the primary purposes of this experiment is to provide you with another professional opinion before you make a decision regarding elective surgery. Therefore, you must have recently seen a surgeon regarding an operation prior to your request for a second opinion.

In addition, you must make arrangements for this surgical consultation through the Second Opinion Referral Center at Blue Cross and Blue Shield of Greater New York; area code 212-481-2658.

Second Opinion benefits are already available as part of your regular Medicare Part B coverage. However, you must meet the deductible and pay 20% of the charges. As stated above, now the benefit is being offered at no cost to you.

If you have further questions regarding this benefit, call the above number or write to:

Blue Cross and Blue Shield of Greater New York
Second Opinion Referral Center
Box 551, Murray Hill Station
New York, NY 10016

Sincerely,

QUALITY ASSURANCE SUBSYSTEM

Approval has been obtained from The Carrier Standards and Development Section of the Medicare Bureau to exclude Experimental Claims from Quality Assurance Review for approximately six months. It has been agreed, however, that the decision would be re-evaluated at that time.

The recommendation to temporarily bypass this process has been accepted for two primary reasons:

- The projected low volume of Experimental Claims.
- The substantial changes required in the Contractor's automated system as well as in the associated program of The Health Care Financing Administration.

If bypassing of this Q.A. Review was not implemented, all of the Experimental Claims would be classified as over payments by the HCFA-QA System.

If these claims were to be subjected to the Q.A. review, the following changes must be made to the automated systems:

- BCBSGNY Q.A. Program (HBOJ330)
  - This program would have to be modified to accept the new "Type of Service" codes S, T, U, V, W and X as valid codes and print them as part of the claim data on the "End of Line Worksheets".
- SSA Q.A. Program (QA2E)
  - This program must also be modified to identify Experimental Program Claims by the unique "Type of Service" codes. Once these claims are identified, this System must:
    1. Disregard the normal routines for applying the deductible amount.
    2. Disregard the normal routine of determining the payment by computing 80% of the allowed charges.
    3. Make payment for 100% of allowed charges up to a maximum of $50.00 for consultation type of services (codes S or T).
    4. Make payment for 100% of allowed charges for Radiology and Pathology Types of Service (codes U, V, W and X).

By excluding these claims from the Q.A. System, only a minor change was necessary in the BCBSGNY Quality Assurance Claims Processing Program.

DENIAL OF REIMBURSEMENT UNDER THE EXPERIMENT AFTER A "ROUTINE CLAIM" HAS BEEN SUBMITTED

Background

It has been our experience in PRESSO, that patients may meet all criteria for eligibility for reimbursement under their Second Surgical Opinion Benefit, EXCEPT that they have not made arrangements for a consultation through the Referral Center.

- If the Second Opinion Surgeon from whom the subscriber received services is a Panel member, and,

- If he agrees to accept the $50.00 fee and not treat the patient, as well as complete the necessary forms, our policy has been to accept these individuals "Retroactively" into the Program and reimburse 100% for the services.

Our original anticipation was to extend this same practice to Medicare Beneficiaries.

Present Status

We have reviewed the problem of how to proceed when it is determined that the Beneficiary is eligible for coverage under the Experimental Program, but a claim has already been processed under the "Routine Benefit".

After discussion with the Project Officer and Regional Office Staff, it has been determined that:

- patients who have not registered with the Referral Center prior to obtaining a second opinion and/or submitting a routine Second Opinion Claim, WILL NOT BE ELIGIBLE FOR INCLUSION IN THE EXPERIMENT.

This position has been taken for the following reasons:

- Claims Related

  If the reimbursement amount under the Routine Benefit was less than it would have been under the Experiment, reimbursement of the additional monies can be made to the Beneficiary, under the Experiment, using the "P6", "P7" procedure outlined under "Duplicate Claims".

If, on the other hand, the reimbursement amount of the Routine Claim was greater than it would have been under the Experiment:

1. There is considerable work involved in adjusting this kind of situation, and;

2. If the consultant has charged the Beneficiary more than the $50.00 fee, we believe it would be extremely difficult to induce the consultant and/or the Beneficiary to refund the balance.

° Correspondence Related

It has been our experience that at least two thirds of the requests for retroactive coverage are received in writing. This means that each piece of correspondence must be individually reviewed to establish the following:

1. Name of physician for whom claimant is requesting second opinion reimbursement.

2. Whether or not he is a surgeon.

3. If so, whether he is a member of the Second Opinion Panel.

4. If so, whether the patient saw a surgeon prior to obtaining this second opinion consultation.

5. Whether surgery was performed since the second opinion.

6. If so, whether the Second Opinion Surgeon performed it.

If any of the above information is missing, a follow-up telephone call or letter is necessary.

If all of the information is present, the analyst must then:

° Check the Medical Directory to answer question number 2.

° Check the CRT to answer questions 4, 5, and 6; (if more than 3 months have elapsed since the dates of service this information will not be on the screen).

° A history interrogation must then be requested and interpreted.

If all of the information is available, and the patient is potentially eligible, the consultant surgeon must be contacted to establish if he will:

° accept the $50.00 assigned fee;

° complete the necessary forms, and;

° agree not to treat the patient or perform surgery.

If all these criteria are fulfilled, the patient would be eligible for the Experimental Benefit and the procedure for registration and completion of forms would be explained and instituted.

If one or more criteria are not fulfilled, a rejection letter must be generated explaining the specific reason(s) for denial.

Because of the time involved in this procedure, it is our preference not to evaluate these individual situations, but rather to respond to them uniformly in writing, advising the Beneficiary that they are ineligible because they have not fulfilled one of the primary eligibility requirements, i.e.: CALLING THE REFERRAL CENTER PRIOR TO ARRANGING FOR A SECOND SURGICAL OPINION.

Disposition and Rationale

Since almost all of the public information material being developed notes that the Beneficiary must call the Referral Center before seeing the doctor to be eligible for the cost free benefit, we believe we have adequately met our responsibility in trying to communicate this condition of eligibility to Beneficiaries.

Additionally, we have requested that all Panel surgeons refer to us Medicare patients who present in their office for a second opinion consultation without first having registered with the Referral Center. Provided a routine claim has not been filed, and these Beneficiaries are otherwise eligible, they will be absorbed into the Experiment and eligible for the cost free benefit .

In summary, then, Beneficiaries who have filed Routine Medicare Claims, and have been reimbursed under the normal Medicare reimbursement criteria (i.e., 80% of allowed charges) may not be subsequently permitted to retroactively participate in the Experimental Program.

Potential For Adjusting The Procedure

If we find after the demonstration begins that:

- the number of requests for retroactive adjustments is large, and;
- denials are causing considerable problems, we may consider reevaluation of this policy despite the inherent problems previously outlined.

PROCEDURE FOR REIMBURSING EXPERIMENTAL SECOND OPINIONS WHEN A "ROUTINE CLAIM" HAS NOT YET BEEN SUBMITTED

Background

There may be instances wherein a Panel surgeon identifies a Beneficiary who presents in his office as eligible for the Experiment despite the fact that they have evidently not registered with the Referral Center. The surgeon, however, may explain the Program and advise the Beneficiary to call us after leaving the office.

These patients may be eligible for reimbursement under the Experiment provided the following criteria have been met:

° The requesting individual must be a Medicare Part B Beneficiary.

° The Beneficiary must have seen a Cooperating Physician on the Panel.

° The Second Opinion Surgeon must not have yet submitted a claim form to BCBSGNY for processing.

° The Second Opinion Surgeon must not be treating the Beneficiary or planning on performing surgery.

Methodology For Verifying That These Eligibility Criteria Have Been Fulfilled

° Following initial contact with the Beneficiary, the analyst will ascertain that requisite 1 and 2 have been met.

° The analyst will then call the Second Opinion Surgeon to insure that eligibility requisites 3 and 4 have been met.

If the response to all of the above is appropriate:

° Claims will be released and procedures for completion and submission explained.

If the response to any of the questions is nonapplicable:

° The Beneficiary will be provided with an explanation of his ineligibility via telephone.

° The physician will be notified in writing.

Blue Cross
Blue Shield
of Greater New York

622 Third Avenue, New York, N.Y. 10017

PRESSO

PROGRAM FOR ELECTIVE
SURGICAL SECOND OPINION

Date _____

Re: Patient: _____ _____

Dear Dr. _____:

Thank you for referring _____ to the Second Surgical Opinion Center. Unfortunately, we are unable to extend the cost-free benefit to this patient, as he/she does not meet the eligibility criteria.

Therefore, you can now submit the routine SSA-1490 claim form for processing.

We appreciate your alerting us to potentially eligible beneficiaries, and look forward to your continued support.

Sincerely,

Patricia O'Connor, Coordinator
Program for Elective Surgical
Second Opinion

POC:ac

REIMBURSEMENT FOR LABORATORY AND X-RAY SERVICES PERFORMED IN A HOSPITAL

The basic incentive for Beneficiary participation in this Experiment is the no-out-of-pocket expense aspect. One of the problems involved in the development of the procedures to administer the Program is how to comply with this commitment when the Second Opinion Surgeon orders tests in a hospital on an Out-Patient basis.

° The SSA 1483, Part A, Out-Patient Claim would be submitted by hospital and processed routinely by the Provider's Intermediary. This may or may not be the Contractor.

° Regardless, the Beneficiary will always be liable for the co-insurance amount of the bill, and may be liable for any deductible amount which is still outstanding.

° Subsequently, full payment for the charge will never be realized.

This has presented a considerable dilemma for both Contractors; BCBSGNY and Blue Cross and Blue Shield of Michigan. Numerous reasons have made it virtually impossible to modify the Model "A" System to identify these claims and pay the deductible and coinsurance amounts.

However, there have been major changes in the specifications for processing Experimental Claims through the Medicare Part B System. These modifications now afford us the mechanism for reimbursing the Beneficiaries after the fact.

The EOMB in this situation can be used as the catalyst for this reimbursement. In this regard, our proposed procedure for processing these claims is as follows:

° Instruct the Beneficiary to pay for the service and send a copy of the EOMB to the Referral Center.

° Upon receipt of the EOMB, the Center will review the Beneficiary's file to insure that the EOMB relates to a Second Opinion Consultation and that it does not represent a duplicate claim or service.

° When these precautions have been satisfied, the Center sets up a new Medicare Part B Second Opinion Experimental Program Claim.

In addition to being the vehicle for reimbursing the Beneficiary for any out-of-pocket expenses which were incurred, the claim will contain, for informational purposes only, the amount paid under the out-patient claim. This is accomplished by the use of "P6" action codes as previously described under "Duplicate Claims".

° A "P6" action code is used to pay a claim item.

° A "P7" action code is used to record an item in claim history, but prevents the item from being paid.

Accordingly, under this approach the Second Opinion Experimental Program claim history will reflect the total charges which were incurred and the total reimbursement.

Example

Assume a Beneficiary incurred a laboratory charge of $15.00 at the hospital.

° When this claim was processed, $5.00 was used to satisfy the Beneficiary's deductible.

° After applying the 80%, an $8.00 payment was sent to the hospital by the Intermediary, thus leaving the Beneficiary with a liability of $7.00.

° In order to compensate the Beneficiary for 100% of the charges, $7.00 or $5.00 deductible and $2.00 coinsurance must be paid to him under the Experimental Program.

° Part II of the SSA 1490 form is completed as outlined below:

PART II—PHYSICIAN OR SUPPLIER TO FILL IN 7 THROUGH 14

7 A. Date of each service	B. Place of service (*See Codes below)	C. Fully describe surgical or medical procedures and other services or supplies furnished for each date given (if lab service, indicate if automated)	Procedure Code	D. Nature of illness or injury requiring services or supplies	E. Charges (If related to unusual circumstances explain in 7C)	Leave Blank
7) 5/22/78	OH	X-Ray of Knee		050	$8.00	
5) 5/22/78	OH	X-Ray of Knee	5-7304	010	$ 7.00	

8 Name and address of physician or supplier (Number and street, city, State, ZIP code)	Telephone No.	9 Total charges	$ 15.00
XXXXX	Physician or supplier code	10 Amount paid	$ 8.00
		11 Any unpaid balance due	$ 7.00

° The net result is:

  ° a payment of $7.00 to the Beneficiary;

  ° reflection in the Second Opinion Experimental Program Claim statistics of a total charge of $15.00, and;

  ° no out-of-pocket expenses to the Beneficiary.

Assume another Beneficiary incurred an out-patient laboratory charge of $9.00. In this case the total amount of the bill was applied to the Beneficiary's deductible responsibility.

° Accordingly, the resulting out-patient claim will be processed as a "no payment claim" and the Beneficiary pays the hospital $9.00.

° In order to cover this claim for 100%, $9.00 must be paid to the Beneficiary.

° Part II of the SSA 1490 form is completed as indicated below:

PART II—PHYSICIAN OR SUPPLIER TO FILL IN 7 THROUGH 14

7 A. Date of each service	B. Place of service (*See Codes below)	C. Fully describe surgical or medical procedures and other services or supplies furnished for each date given (if lab service, indicate if automated)	Procedure Code	D. Nature of illness or injury requiring services or supplies	E. Charges *(If related to unusual circumstances explain in 7C)*	Leave Blank
5/22/78	OH	X-ray of knee	5-7304		$9.00	
					$	

8 Name and address of physician or supplier *(Number and street, city, State, ZIP code)*	Telephone No.	9 Total charges	$ 9.00
XXXXX	Physician or supplier code	10 Amount paid	$ Ø
		11 Any unpaid balance due	$ 9.00

Adjustment of Beneficiary's Deductible Status

This leaves the problem of adjusting the Beneficiary's Part B deductible status in Baltimore. When an out-patient claim is processed, the Beneficiary's deductible must be met before payment can be made to the Provider or Beneficiary.

° The Model "A" System does this automatically.

° Therefore, after the out-patient claim has been processed, the Beneficiary's deductible has been reduced by the amount of the covered charges. Any future Medicare claims incurred by the Beneficiary will be processed accordingly.

The Model "A" System cannot be modified. Therefore under the Experimental Program, the Beneficiary will be reimbursed for the deductible amount.

° After the Beneficiary has been reimbursed for the amount which was applied to the deductible, an "A" Query will be used to adjust the Beneficiary's deductible status in Baltimore.

° The out-patient claim will be processed routinely.

° The Beneficiary will submit a copy of the EOMB to the Second Opinion Referral Center.

° The Center will insure that the charges reflected on the EOMB are related to second opinion.

° They will then develop a Medicare Part B Second Opinion Experimental claim to reimburse the Beneficiary for any out-of-pocket expenses that were incurred.

  If these out-of-pocket,expenses include the reimbursement of the Beneficiary's deductible responsibility, a copy of the EOMB will be made.

° The Experimental claim will be processed routinely.

° The copy of the EOMB will be routed to the SMI/Claim Adjustment Department.

  The SMI/Claim Adjustment Department will query the Model "A" System via a "MDA-38" transaction to obtain the claim's "Batch Number".

  Utilizing the Batch Number they will determine if the Batch has been accepted by HCFA from the "Batch Status Report." When this has been established, an "A" Query to Baltimore, will be processed using the MC646 form to adjust the Beneficiary's deductible status.

The net result is that the Beneficiary is reimbursed for 100% of the incurred charges and his deductible status in Baltimore reflects the amount which was to be met prior to processing the out-patient claim.

REIMBURSEMENT TO QUEENS PROVIDERS

Background

- During the early stages of processing, the system queries the Provider File to determine the Providers status, specialty, etc.
- Providers (Physicians or Vendors) must be on this file and coded as "Medicare Eligible" for a claim to be paid.
- Unless both of these conditions are met, the claim is rejected.
- Since BCBSGNY, instead of the Carrier (GHI), will be processing the Experimental Claims submitted by Queens County Providers, adjustments had to be made in the system to prevent these rejections from occurring.

The following describes the mechanism by which this will be accomplished:

- Physician Claims
  - On the basis that the physicians who will be rendering the second opinion are already on the Provider File as a result of our PRESSO Program, there appears to be no problem regarding this requirement.
  - However, since we do not routinely process their claims under Medicare, there will be no "Medicare Eligible" code for these Providers, and the claim will be rejected. Therefore, an additional step will be introduced into this validation.
    1. The Medicare Part B Second Surgical Opinion Experimental Program Claims will be assigned a special "Batch Number" which is part of the Internal Control Number (ICN) assigned to every Medicare Claim.
    2. Two Batch Numbers (767 and 768) have been assigned to Second Opinion Claims and one Batch Number (769) has been assigned to Third Opinion Claims.
    3. These numbers have been reserved for the processing of these Experimental Claims only.
  - Before rejecting the claim, the System will determine if the unique "Batch Number" is appended.
  - If so, the Provider will be considered "Medicare Eligible" and the claims will be processed for payment.

° Laboratory Claims

  ° When a laboratory submits a claim, the System insures that the procedure code is valid and that the laboratory is authorized, by its assigned specialty to perform the procedure. (Physicians are exempt from this validation).

° Mechanism

  ° The System accomplishes this by first matching the procedure code against the "Procedure to Specialty File".

  ° If the file does not contain the procedure code on the input transaction, the claim is rejected.

  ° When a match is obtained, the System extracts the "Laboratory Specialty Code" which is assigned to that procedure.

  ° The System then searches the "Medicare Laboratory Certification File". This file is arranged in Provider Number order and contains the Laboratory Specialty Codes which have been authorized by the Medicare Bureau for each Provider.

  ° The System matches the "Laboratory Code" it obtained from the "Procedure to Specialty Code" file, to the "Specialty Codes" which have been appended to the Provider's record on the "Laboratory Certification File".

  ° If the Provider has not been authorized to perform that service, the claim is rejected.

° Lab Claims - Queens Providers

  ° We have been advised by GHI that there are apparently less than 25 certified laboratories in the county of Queens.

  ° We have authorization from the Regional Office to append these Providers to our System.

° Processing

  ° We see no problem in processing the claims, employing the same approaches outlined in the System Modifications for processing all laboratory claims.

  ° If the claim has the special Batch Number appended, the Provider will be considered "Medicare Eligible" and the claim will be processed.

° Control Mechanism

  ° No other Queens Provider claims will be assigned these unique Batch Numbers.

  ° Without these Batch Numbers and without the Providers' Numbers being appended to our Provider File, the System will automatically reject the claim.

UNIQUE BILLING SITUATIONS

Charges In Excess Of Prevailing Fee Screens

° As part of input validation, the Medicare Part B system contains maximum dollar amounts which can be entered for payment of x-ray and laboratory charges.

° If the payment exceeds these prevailing fee screen amounts, the system will not accept the transaction.

° In rare instances, the Referral Center may be required to approve a payment which exceeds these fee screens.

° When this occurs, the Referral Center will initiate a call to the Provider requesting they make an adjustment in charges.

° If the Provider will not adjust the charges, the control clerk will utilize the range code procedures to allow the system to reimburse the billed amount. The system provides this facility to make payments over and above the normal amounts using a multiplier and a set fee. The system multiples the two to arrive at the payment.

For example:

Multiple Service		Fee		Payment
20.0	x	10	=	$200.00
00.1	x	10	=	$ 1.00
06.0	x	10	=	$ 60.00

For ease of computing, it is recommended that a $10.00 range code "fee" be used whenever possible.

° To insure that only the amount approved is paid, all Second Opinion Experimental Claims will be manually audited prior to the generation of the check.

Physician Charges In Excess Of Screens

° No such procedure exists to reimburse physicians for charges in excess of $50.00.

° If such charges are received, the physician is called and reminded of his agreement to accept assignment of up to $50.00.

° It is not anticipated, nor has it been our experience under PRESSO, that the physician consciously expects reimbursement in excess of $50.00. It should be noted however that for profile purposes, the physician may bill his usual and customary fee which may exceed $50.00. However, since Experimental Claims are bypassing profile edits, the fee will be coded as payable at $50.00.

Laboratory And X-Ray Charges
Not Consistent With The Diagnosis

If, during quality review of the SSA 1490, it is recognized that the billed ancillary services are inappropriate to the diagnosis, the Provider will be called.

° If additional diagnostic information is obtained which clarifies the necessity of the tests, it will be added to the diagnosis on the SSA 1490 and the claim will be approved for payment.

° If the tests were billed in error, the appropriate deletions will be made by the Center and the claim will be approved for payment.

° It is not anticipated, nor has it occurred in our PRESSO experience, that services will be performed that are totally inconsistent with the diagnosis. However, in our commitment under the Experiment to provide a "NO OUT-OF-POCKET EXPENSE BENEFIT" to the Beneficiary, these unrelated services will be paid.

RESEARCH DESIGN

INTRODUCTION

This demonstration project is designed to determine the impact of a voluntary Second Surgical Opinion Program on elective or postponable surgery for Medicare Part B Beneficiaries.

An evaluation of the Project will provide estimates of the program's effects on the health status of the Medicare population, as well as the medical cost savings versus the medical and administrative costs of the Experiment.

The data generated will include the characteristics of patients, first opinion (primary) surgeons, second/third opinion (consultant) surgeons, the types of procedures initially recommended or discussed as well as the recommendations and non-recommendations for surgery by the second/third opinion physicians.

Medicare claim forms will also be available for determining whether surgery or alternative medical treatment was performed and the costs incurred. In addition, detailed program operation and promotional costs will be supplied.

Following is a description of the experimental design of the program, the data base and data sources.

I. Selection of a Design for Program Operation and Data Collection

Several approaches to creating a study population and a control group design were considered. Because of expected low utilization of this voluntary second surgical opinion benefit, quite large population groupings had to be considered -- with the knowledge that the beneficiaries had to be given a clear understanding of their eligibility and the availability of the program. Three basic approaches were studied, the first two were rejected.

A. Random Sample Population in One Geographic Area

While random sampling may be the most scientific approach in designing a study to test utilization and outcomes, it has a number of constraining features which make it inadvisable and impractical to implement in this situation. We decided not to select Experimental and Control Group samples from an area's Medicare Part B covered population because it would:

- require turning away patients who are not in the sample treatment group, thereby creating negative attitudes among the beneficiaries and providers.

- affect participation by physicians who could be placed in an untenable position vis-a-vis their patient, some of whom would be eligible and some of whom would not.

- require a population base for statistical reliability which would necessitate drawing beneficiaries from a geographic area not easily controlled or administered.

- make "case finding" and education more difficult and very expensive.

- require an educational program to encourage participation targeted to avoid the control group.

B. One Population, Pre and Post Program Design

The Experiment will be conducted during a period in which national, state, and regional health care strategies for cost containment and altering of surgical patterns are being both planned and implemented. The measurement of the impact of a surgical consultation program would be confounded by the effects of other programs unless the design allowed for comparisons with a control group(s).

C. The Non-Equivalent Control Group Design*

A pre-test post-test control group design based on geographically defined groups underlies program operation and data collection for this project.

Though the Medicare population may not be randomly distributed between the treatment and control groups, and these geographically defined groups may not have identical surgical specialty to population ratios, the differences in these parameters in the pre-test period will not be substantially different. There should not be any qualities unique to either of these populations which would bias findings on the effectiveness of a surgical consultation program based upon comparisons of surgical rates prior to and at the conclusion of the three year experimental period.

In a geographically distinct control group, surgical rate comparisons to measure indirect effects of the program can also be made; e.g., impacts on the behavior of surgeons and patients within the experimental area other than the first opinion surgeons and patient participants. This impact, the "sentinel" effect, may be attributed to the existence of the program and could be more substantial than the direct program effect.

*For a detailed discussion of this "quasi experimental" design, see Experimental and Quasi Experimental Designs for Research, Campbell, Donald T., and Stanley, Julian C. Rand McNally and Co., Chicago, 1966, pp. 47-50.

TREATMENT GROUP POPULATION

Originally, Blue Cross and Blue Shield of Greater New York proposed to limit its experimental design to:

- Medicare beneficiaries residing within the 16 county area which it serves as Part B Medicare Carrier, and;
- Medicare beneficiaries who seek care from surgeons in the 16 county area.

Selection of the entire Medicare Part B population from this area as the treatment group had the following advantages:

- It permitted concentration in an area of 16 contiguous counties in which Medicare Parts A and B are already administered by BCBSGNY.
- The Corporation had an established data base as Intermediary and Carrier for Medicare in these 16 counties.
- BCBSGNY had already established the Program for Elective Surgical Second Opinion (PRESSO) in this region and is therefore experienced in the organization, implementation, and data collection involved in a Second Surgical Opinion program of this type.
- Physician cooperation, including the participation of surgical consultants in PRESSO had already been accomplished in this area and could readily be obtained for this project as well.
- The entire Medicare Part B enrollment would constitute the program eligible population. There would be no need to resort to random sampling and control group assignment with the attendant problems this would create.
- Program findings could be generalizable because of the presence of large metropolitan as well as non-urban and rural areas in this region.
- The enrolled Medicare population in the 16 counties is large enough to produce credible data in a relatively low utilization program.
- Follow up data relating to hospital admissions, and/or out-patient treatment of the study group would be available through the Carrier's claims history files.

Sixteen County Program Area

The sixteen county program area would comprise four of the five counties of New York City and twelve adjacent counties in the southern portion of New York State.

COUNTY LIST

Bronx	Greene	Richmond
Brooklyn	Nassau	Rockland
Columbia	New York	Suffolk
Delaware	Orange	Sullivan
Dutchess	Putnam	Ulster
		Westchester

Modification in Treatment Group Population

With the National Second Opinion Medicare Part B benefit planned for implementation almost concurrent with the Experimental Program, posters, ads, brochures, public service spots, and educational programs unexpectedly had to be redesigned to accommodate and explain the differences between these two benefits.

To avoid the potential of further confusing the eligible population by introducing a paragraph excluding all Queens* residents seeking Second Surgical Opinions from Providers in that County, it was decided to explore the possibility of including the above in the study sample.

A meeting was arranged with the appropriate Administrative Staff of Group Health Incorporated, the Carrier in Queens County.

It was collectively agreed that revising the sample population would:

° provide equal access to a cost free benefit for all eligible beneficiaries in the Greater New York area.

° increase program utilization and therefore, expand the study group sample.

° avoid a complicated and confusing advertising campaign.

Modifying the Experiment to include the Group Health Incorporated population is not without its own problems in terms of planning, implementation and evaluation, not only for the Contractor and Evaluator, but for Group Health Incorporated as well.

We recognize and appreciate the time and effort required by this Carrier in affording us the opportunity to extend this benefit to include Beneficiaries and Providers within their service area.

*This is the Fifth County of New York City heretofore excluded.

II. Treatment Group

The target population then, will be the 1.5 million Medicare Part B resident population of the seventeen southern counties in New York State. This will include the disabled who comprise seven percent of all eligible participants.

Table I
Medicare Population Groups and Surgical Rate Index in 17 Counties, New York State and the United States 1975 a/

Population Groups	Seventeen Counties	New York State	United States
Total Population 1975	12,543,000	18,561,000	231,137,000
Age 65 and Over	1,405,000	2,043,000	22,400,000
Disabled Eligibles	105,000	153,000	1,920,000
Percent - 65 and over of total population	11.2	11.0	10.5
Percent Disabled Eligibles of total Eligibles	7.0	7.0	7.9
Surgical Rate Index b/	.93 c/	.96	1.00

a/ Statistical Abstract of the United States - 1970, 1975. Office of Planning Coordination, State of New York - 1975

b/ Social Security Administration - 1973 data.

c/ To derive a surgical rate index for the 17 counties with the U.S. = 100, and New York State = .96, the volume of surgery relative to the size of the Medicare population in the 17 counties and the rest of the state as found in a 1975 BCBSGNY one Day Census - discharge survey was used.

III. Recommendation for Control Groups

It is not within the scope of our programmatic activity to select the appropriate control group(s). However, we do urge consideration of the following elements in making such a selection.

A control group can be selected by aggregating fully operational PSRO areas which approximate the Medicare surgical rates and the surgeon specialist to Medicare population ratios of the 17 counties in New York State, and are not Medicare Part B Second Surgical Opinion experimental areas.

A second control group can also be selected which has neither a Medicare Part B Second Surgical Opinion Program nor a fully operational PSRO.

Advantages

° Surgical rate data compiled by the Health Care Financing Administration on a PSRO basis lends itself both to data collection and to the selection of control groups to obtain insights into the separate effects of Second Surgical Opinion and PSRO Programs in the containment of Elective Surgery.

° PSRO's comprise one or more whole counties and thus provide a ready statistical basis for matching surgeon/population ratios. For example, in Illinois, PSRO III (Cook County) and PSRO II (McHenry, Dupage, Kane and Lake counties) are key counties of the Chicago, Illinois Standard Metropolitan Statistical Area (SMSA). This SMSA has a surgical specialist/population ratio close to that of the sixteen counties.

Surgical Specialist/Medicare Population Ratios 1974

Sixteen counties (New York State) 3.72 per thousand population

Chicago, Illinois SMSA 3.24 per thousand population

Source: Population data from the Statistical Abstract, 1976. Surgical Specialist data from Physician Distribution and Medical Licensure in the U.S. 1974. American Medical Association.

Additional research would be required to examine surgical rate data and other factors in these and other potential control group areas before an appropriate selection is made.

IV. Anticipated Program Size

Taking into account age and health status differences, the following expectation of program participation are estimates based on the experience of PRESSO. Because of the difficulty in predicting the impact of the intensive outreach activities planned for the Experiment, these estimates are expressed in ranges for each of the three years.

1st year: 500 - 700 requests for second surgical opinions
2nd year: 800 - 1,000 requests for second surgical opinions
3rd year: 1,200 - 1,400 requests for second surgical opinions

Using the midpoints of these estimates, the total for the three year period is expected to be approximately 2,800. Program participation of this magnitude will permit valid inferences to be drawn regarding differences in the non-confirmation rates for the leading surgical procedures.

V. Implications of Program Size

With sufficient program size, at least a rough approximation can be made of the extent of questionable surgery in the entire Medicare population by examining the non-confirmation rates for leading elective surgical procedures as well as the total non-confirmation rates. If it could be assumed that program participants during the Experimental period are representative of the entire Medicare surgical population during this same period, we calculate that approximately:

° 500 Second Opinions would be needed to achieve a 95 percent level of confidence that the overall non-confirmation rate (NCR) in the 17 county Medicare surgical population would not differ by more than four percent from the overall NCR found for Program participants.

° 2,000 cases would be needed to achieve a 90 percent confidence level that the NCR for the leading elective surgical procedures in the 17 county area would not differ by more than five percent from the NCR found in the Program.

Assumptions about the representativeness of persons seeking second opinions however, have serious limitations for the inference stated above. Comparisons of NCR's in voluntary and mandatory programs suggest that the more questionable surgical cases are likely to be over-represented in a voluntary surgical opinion program.* Also the shifting incidence of specific diseases over time, evolving clinical standards, institutional changes, public attitudes and the program itself will in the future influence both the proportion of specific procedures, as well as the confirmability of cases for a particular procedure.

*See Eugene McCarthy and Ann Kamons; "Voluntary and Mandatory Presurgical Screening Programs:"An Analysis of Their Implications" paper presented in May, 1976 to the American Federation for Clinical Research; for operational data from both types of programs.

Thus, while the experimental program described in this proposal can expect to obtain at least 2,000 program participants to provide the basis for valid findings, caution is advised in drawing conclusions because of the questions about representativeness as described above.

Nevertheless, reasonable approximations to these important dimensions of the surgical universe and surgical program planning should be possible from the findings of the Experimental Program.

DATA FOR PROGRAM EVALUATION

Experimental group data for Program evaluation will be available on a per case basis.

Sources

- Patient Related
  - The reported characteristics of each participant will include age, sex, marital status, disability status, diagnosis and recommended surgery.
- Surgeon Related
  - Characteristics of the primary surgeon will be known for each case.
  - This will permit study of the association of non-confirmed surgical recommendations with characteristics of the primary surgeon, such as age, medical school attended, years since graduation and specialty.
  - Similar data will also be available for the consulting surgeon.
- Surgical Procedures Related
  - For each case, the surgical procedure discussed or recommended will be identified by a multiple digit ICDA code, as will the underlying diagnosis.
  - For confirmed cases, the specific surgical recommendation both by the primary and the consultant surgeon will be known.
  - For the non-confirmed cases, the surgical recommendation by the primary surgeon and the reason(s) for non-confirmation given by the consulting surgeon will be presented.

Data collection will take into account the voluntary nature of the Program. While participants will take the initiative in applying to the Program, their reluctance to permit contact with the primary surgeon will require that the applicant be the major source of information concerning the initial surgical recommendation.

Two aspects of the reported surgery which might otherwise be clouded with ambiguity will be clarified, ie:

- There are two possible meanings that can be attributed to a "discussed" as opposed to a "recommended" surgery.
  - The First Opinion Surgeon informed the patient that surgery may be necessary in the future, but that it would be contingent on the natural course of the disease and/or the effectiveness of current medical management.
  - The First Opinion Surgeon informed the patient that surgery was not necessary without any qualifications.

One category could suffice to incorporate both types of "discussion". However it is most important that (a) is not included in "recommended surgery". A Second Opinion Surgeon non-confirmation pending "further medical management" in such a case would essentially be an identical recommendation to that made by the First Opinion Surgeon.

To permit relevant distinctions without introducing unnecessary complications, the following two (2) situations will be classified under "Surgery Discussed".

° If the patient is seeking a second opinion despite the non-recommendation of the need for surgery by the primary surgeon.

° If the surgeon indicated that surgery may be necessary in the future, but that it would be contingent on the natural courses of the disease and on the effectiveness of medical management.

The other aspect of the surgical recommendation for which precise information will be obtained is the use of pre-operative tests by the primary surgeon. It is possible that the recommendation for surgery reported by the patient was contingent on test results. Therefore, it will be determined what tests, e.g., biopsies have already been performed, whether the results were positive or, if not performed, whether the first opinion surgeon intends to perform such tests prior to a major surgery.

This is to elicit the precise nature of the recommendation of the First Opinion Surgeon and the Second Opinion Surgeon, which will allow for valid comparisons between the first and consulting surgeons' evaluation of the patient's condition.

Claim History Data

° Part A and Part B Medicare Data

  ° Medicare claims data will comprise the medical history including surgeries performed, other hospitalizations, and office and clinic visits both by Program participants and by all other Part B Medicare Beneficiaries. Hospital and physician payments are also part of this data base.

  ° Through linkage with Medicare claims data it will be possible to determine whether surgery was performed both for the confirmed and for the non-confirmed cases.

  ° For those patients who had surgery recommended by a second/third surgeon, claims history will be available to identify:

    ° those who had surgery within specified periods;
    ° those who did not.

    This could permit insight into:

    ° the characteristics of patients who are surgical "intransigents", i.e., who reject surgery even with one or more consultant recommendations;

- the extent to which desirable surgery is not being performed.

- For those patients who did not have surgery recommended by a second/third surgeon, claim history will be available to identify:

  - those who had surgery;

  - those who did not have surgery.

Materials for Program Evaluation

In addition to devising an evaluative framework to facilitate the development of this research protocol, BCBSGNY has evaluated a Second Surgical Opinion Program offered to its own subscribers. Preliminary findings have been published and protocols and plans for follow-up studies are currently in preparation. We would be pleased to share all of this material with the Evaluator.

Our materials include the following:

- Techniques for estimating both direct and indirect program impact; the latter via the "sentinel effect".

- A methodology for measuring both direct and indirect program cost savings, the latter including the impact on employment and household activity.

- A method of adjusting the cost savings calculations to take into account "surgical intransigents" and those who would have visited a consultant even without a Second Opinion Program.

- Techniques for adjustment of insurance reimbursement data to reflect accurately the cost of surgical hospital stays.

- An approach for measuring medical outcome.

DATA COLLECTION

Purpose

The data collected in this demonstration will be used by the organization which successfully bids on HCFA's RFP to evaluate this Experiment.

Each of the forms being utilized for data collection is designed to provide information necessary to analyze the impact of a Second Opinion Program on total Medicare program costs, surgical rates, patient and physician decision-making processes regarding surgery, and the health outcomes of Beneficiaries who do and do not utilize the services.

Background

These data collection tools, revised in conjunction with the Michigan Blue Cross and Blue Shield Plan as well as HCFA, resemble the instruments designed by BCBSGNY for use in its regular business Second Opinion Program.

Changes have been made to accommodate the needs of both Contractors while still providing uniform data for use by the evaluator.

Mechanism (Program Data)

Program data will be coded where appropriate, then keypunched directly from the data collection tools without the use of intermediary documents. They will then be edit checked to eliminate inconsistencies and to correct omissions. All form recording will be monitored at an early stage to insure accuracy and completeness. The data will then be processed onto a tape for submission to the evaluator.

Mechanism (Payment Data)

In regard to the payment of these cases, the claims history will be maintained on a separate tape. The file format of this tape will be the same as the "Pending Master File". It will be updated daily and used to meet our obligations to provide the Evaluator with payment record information.

Sensitive Data

"No data pertaining to religious or political beliefs or sex behavior and attitudes will be collected. Information will be required, however, concerning Medicare Beneficiaries' medical/surgical condition. It is necessary to collect such information in order to refer the Beneficiary to a consultant of the appropriate specialty and to establish baseline measures for health status evaluation. Upon calling the Referral Center to request a surgical consultation, the Referral Center will read a statement to the caller stating the legal authority for collecting the information, whether disclosure of such information by the individual is mandatory or voluntary, the purpose and routine uses for which the information will be used, and the effect on the individual if the individual does not provide the information. The Referral Center will also offer to send a copy of the intake form to the Beneficiary. All other forms (i.e., First Opinion Physician/Surgeon Report and Consultant's Report) will automatically be sent to the respondent with the above information printed on the forms."[2]

Sources Of Data

Data for Program Evaluation will be available on a per case basis obtained from the following:

° The Program participant.

° The First Opinion Surgeon (when confidentiality is not requested by the participant).

° The Second, and where applicable, the Third Opinion Surgeon.

° Claims history data.

The following tools will be employed:

° Referral Center Intake Form

° First Opinion Surgeon Report

° Consultant Report

° Experimental Claim Form (SSA 1490)

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[2] Galblum, Trudi. "Supporting Statement for OMB Forms Clearance for Second Surgical Opinion Demonstration Project," Health Care Financing Administration, 1978.

Intake Form

The Intake Form is the only tool by which the Referral Center obtains certain information about the beneficiary, the Provider, and the recommended surgery. Intake Form data will be available for the evaluator to examine such issues as:

° the relationship between diagnosis and recommended or discussed procedure and the usage of Second Opinions;

° the influence of basic Beneficiary and Provider characteristics on their respective behavior regarding surgery and pre-surgical consultations;

° the extent of penetration to the eligible population, of various educational efforts.

Operationally, this form will serve such purposes as:

° facilitating the determination of Beneficiary eligibility;

° tracking whether Beneficiaries with scheduled appointments, actually follow through with the consultation.

° insuring that appropriate forms are provided for First/Second and/or Third Surgeons.

The tool contains the following information:

° Beneficiary Personal Profile

  ° HIC number

  ° age

  ° disability status

  ° sex

  ° marital status

  ° occupation

  ° residential location and telephone number

  ° identification of any other insurance coverage

  ° eligibility status

  ° how the Beneficiary learned of the Program

° Beneficiary Medical Profile

  ° date of last contact with Primary Surgeon

  ° diagnosis or nature of complaint (as reported by the patient)

  ° diagnostic tests performed to date and results

  ° biopsies performed and/or intended and results

  ° type of surgical procedure recommended or discussed

  ° whether surgery was scheduled, and if so, where.

° Primary Surgeon Profile

  The identity of the First Opinion Surgeon will be obtained from the Beneficiary, and the following information from State Medical Directories:

  ° location of practice

  ° Board Certified status

  ° specialty and sub-specialty

  ° medical school attended

  ° year of graduation

  ° type of practice

  ° hospital affiliations.

° Second/Third Opinion Surgeon Profile

  In order to avoid unnecessary duplication of information that is readily available, no provision has been made on the Intake Form for recording Profile information on the Second/Third Opinion Surgeons. Instead, a tape containing the same data as itemized above for each Second Opinion Surgeon on the Panel will be provided for the Evaluator.

REFERRAL CENTER INTAKE

SECOND SURGICAL OPINION PROGRAM

DATE OF CONTACT WITH CENTER	TIME RECEIVED	TIME COMPLETED	TOTAL MINUTES	CODE	ANALYST NAME

BENEFICIARY NAME	HIC NUMBER	OCCUPATION	RETIRED 1 YES 2 NO	CODE

STREET ADDRESS	COUNTY	CODE	STATE	CODE

ZIP CODE	APT.	TELEPHONE	DATE OF BIRTH MO. DAY YEAR	SEX 1 M 2 F	MARITAL STATUS 1 M 2 D 3 W 4 S 5 A(SEP)	DISABLED 1 YES 2 NO

DIAGNOSIS — CODE

SURGICAL PROCEDURE (CHECK ONE AND DESCRIBE) 1 DISCUSSED 2 RECOMMENDED — CODE

NAME OF F.O.S.	CODE	STREET ADDRESS

SPECIALTY	CODE	SUB SPEC.	CODE	COUNTY	STATE	ZIP CODE

DATE OF MOST RECENT APPOINTMENT WITH SURGEON — MO. DAY YEAR

WITHIN WHAT TIME FRAME: 1 ONE MONTH 2 FOUR MONTHS 3 MORE THAN FOUR MONTHS

WERE DIAGNOSTIC TESTS PERFORMED? 1 YES 2 NO — CODE

IF YES, TYPE: _____ RESULTS _____ CODE

IF SURGERY IS TO TREAT A MALIGNANCY, WAS A BIOPSY PERFORMED? 1 YES 2 NO

IF BIOPSY DONE, WERE RESULTS POSITIVE? 1 YES 2 NO

IF NOT DONE, PLANNED? 1 YES 2 NO

IF SURGERY WAS RECOMMENDED, HAS IT BEEN SCHEDULED? 1 YES 2 NO

IF YES, DATE SCHEDULED — MONTH DAY YEAR

IS BENEFICIARY ELIGIBLE FOR A SECOND OPINION? 1 YES 2 NO

MEANS BY WHICH ELIGIBILITY ESTABLISHED 1 CRT 2 BEST FILE 3 Z QUERY

IF NOT ELIGIBLE, CHECK REASON

1 PROCEDURE NOT COVERED, EMERGENCY-MEDICAL
2 PROCEDURE NOT COVERED, CONTRACT EXCLUSION
3 CONTRACT NOT CURRENT
4 OVER 120 DAYS SINCE SEEN BY SURGEON
5 SECOND OPINION OBTAINED WITHOUT ARRANGING THROUGH REFERRAL CENTER
6 OTHER (SPECIFY)

FOR ELIGIBLE BENEFICIARIES ONLY

LOCATION OF SURGERY	NAME OF HOSPITAL RECOMMENDED	CODE
1 HOSPITAL INPATIENT 2 HOSP. O.P.D. 3 M.D. OFFICE 4 OTHER		

DOES BENEFICIARY WISH F.O.S. TO BE INFORMED OF CONSULTATION? 1 YES 2 NO IF NO, GIVE REASON:

IF YES, GIVE DATE F.O.S. FORMS SENT — MO. DAY YEAR

WAS S.O.S. INFORMED OF F.O.S. COMMENTS? 1 YES 2 NO

DATE RETURNED — MO. DAY YR.

NAME AND PHONE NUMBER'S OF SURGEONS GIVEN TO BENEFICIARY

1.

2.

3.

DO YOU WISH REFERRAL CENTER TO SCHEDULE APPOINTMENT FOR YOU? 1 YES 2 NO

IF YES, CONVENIENT DATES AND TIME:

HOW DID YOU HEAR ABOUT THE PROGRAM? 1 SR. CITIZEN GRP. 2 NEWSPAPER 3 RADIO 4 T.V. 5 FRIEND 6 RELATIVE 7 OTHER (SPECIFY)

DOES BENEFICIARY HAVE OTHER INSURANCE? 1 YES 2 NO

IF YES, TYPE: 1 MEDICAID 2 BC/BS 3 COMMERCIAL 4 OTHER (DESCRIBE)

F.O.S. PROFILE INFORMATION

F.O.S. NAME	PROVIDER CODE	CERTIFIED 1 YES 2 NO 3 UNKNOWN IF YES, DATE MO. DAY YEAR

TELEPHONE	MEDICAL SCHOOL	CODE	YEAR OF GRADUATION

HOSPITAL AFFILIATIONS	CODE		CODE
1		3	
2		4	

NAME OF CONSULTANT SELECTED FOR S.O.	PROVIDER CODE	DATE AND TIME OF APPOINTMENT

IF BENEFICIARY ARRANGED APPOINTMENT, DATE CENTER CONFIRMED WITH S.O.S.	IF CENTER ARRANGED APPOINTMENT, DATE BENEFICIARY NOTIFIED

DATE APPT. CARD & FORMS SENT TO BENEFICIARY	CHECK THIS BOX IF BENEFICIARY DID NOT KEEP APPOINTMENT ☐	IF NO, WAS APPT. RESCHEDULED ☐ YES ☐ NO	IF YES, DATE AND TIME RESCHEDULED

THIRD OPINION APPOINTMENTS

DATE BENEFICIARY CALLED FOR THIRD OPINION	REASON

	CODE

NAME AND PHONE NUMBERS OF SURGEONS GIVEN TO BENEFICIARY

A.

B.

C.

NAME OF CONSULTANT SELECTED	CODE	DATE AND TIME OF APPOINTMENT

IF BENEFICIARY ARRANGED APPOINTMENT, DATE CENTER CONFIRMED WITH S.O.S.	IF CENTER ARRANGED APPOINTMENT, DATE BENEFICIARY NOTIFIED

DATE APPT. CARD & FORMS SENT TO BENEFICIARY	CHECK THIS BOX IF BENEFICIARY DID NOT KEEP APPOINTMENT ☐	IF NO, WAS APPOINTMENT RESCHEDULED? ☐ Yes ☐ No	IF YES, DATE RESCHEDULED

RECORD OF TELEPHONE CALLS

DATE CALLED	TO/FROM	REASON	OUTCOME

The authority for collecting the above information is contained in section 402 (a) of the 1967 Amendments to the Social Security Act as amended by section 222 (b) of the 1972 Amendments to the Social Security Act, P.L. 92-603. Disclosure of such information is voluntary.

The information collected on this form will be used to conduct referrals and to evaluate the impact of the program. If individuals do not provide the information, they may not be able to obtain a consultation with waivers of co-payment and deductible requirements.

First Opinion Surgeon Report

In an effort to obtain as much medical data as is available that will:

° aid the Second Opinion Surgeon in rendering a consultation, and, provide additional information for the Evaluator, the analyst will request of all eligible Beneficiaries, permission to mail First Opinion Surgeon forms.

The beneficiary will be made to understand that this option is voluntary, and should he desire confidentiality, it does not prevent access to the cost free benefit.

° This form contains:

  ° beneficiary HIC number

  ° date of examination

  ° diagnósis

  ° history and findings of significance

  ° whether a surgical procedure was recommended or discussed

  ° the type of surgical procedure

  ° whether a biopsy was performed to date and the results; if not, whether a biopsy is planned

  ° if surgery is to be performed, where; and if in a hospital, the name of the institution.

  ° type of practice

Consultant's Report

The consultant's report is used by the Second and Third Opinion Surgeon to record their findings regarding the beneficiary's need for elective surgery. This information is necessary for the Evaluator's assessment of the impact of a Second Opinion on the patient's decision to proceed with, or defer surgery.

° On this form the consultant indicates:

  ° diagnosis

  ° if the need for surgery is confirmed or non-confirmed

  ° if confirmed:
    ° the procedure recommended
    ° the location where surgery should be performed.

  ° if not confirmed:
    ° reason for non-confirmation

  ° laboratory and x-ray tests ordered:
    ° reason for ordering and results.

  ° whether the findings were discussed with the Primary Surgeon

  ° Beneficiary's ethnicity

SSA - 1490 Claim Form

The standard Medical Insurance Benefits - Request for Medicare Payment (SSA-1490) which has been colored yellow for the Experimental Program will be used for submission of Provider Charges.

To further aid claims processing staff at BCBSGNY, as well as the Providers of services in identifying these claims as unique, both in terms of payment and handling, "Medicare Part B Second Surgical Opinion Experiment" will be stamped across the face of the claim.

A second Experimental SSA-1490, additionally stamped with "For X-ray and Laboratory Charges Only" will be available for use by physicians and vendors.

The information on both of these forms will provide the Evaluator with data relative to:

° dollars expended in reimbursement for services under the benefit

° types and amounts of ancillary services ordered, by diagnosis, and specialty of Second Opinion Surgeon.

PROCEDURE FOR HANDLING FIRST OPINION SURGEON FORMS

Background

First Opinion Surgeon forms will be mailed to the Primary Physician whenever permission is obtained from the Beneficiary.

At the time of the writing of this Protocol, it had not yet been clearly established whether we could request this information from the First Opinion Surgeon without an accompanying signed release from the Beneficiary.

If this is needed, the procedure outlined below will require revision.

It is recognized that the logistics of obtaining this release from the Beneficiary, mailing it to the First Opinion Surgeon and awaiting his report will, in most instances, probably preclude the possibility of providing the Second Opinion Surgeon with any information prior to the Beneficiary's visit.

However, it is hoped that the information could still be obtained, since it will add dimension to the Evaluator's data regarding the Beneficiary's initial diagnosis and surgical procedure recommended or discussed.

Mechanics:

Prior to mailing:

- The date of the patient's appointment with the Second Opinion Surgeon is recorded in the upper right hand corner of the form.
- The patient's name and date are recorded in the log book.
- An explanation of the purpose of the form and a stamped return envelope are enclosed.

Upon return of the completed form the control clerk will:

- Enter the date in the log book next to the appropriate name.
- Establish if the return of the form pre-dates the Second Opinion Surgeon's appointment. If so:
  - the form and patient's folder are given to an analyst.
  - the analyst calls the Second Opinion Surgeon and relays the information on the First Opinion Surgeon form. She then:
  - enters a check next to the appropriate items on the intake form regarding receipt of the form and notification of the Second Opinion Surgeon.

- If the return of the form post-dates the Second Opinion Surgeon appointment, the clerk will:
  - file the form in the patient's folder
  - enter a check next to the appropriate item in the Intake Form regarding non-relay of the content to the Second Opinion Surgeon.

PROCEDURE FOR HANDLING CLAIM FORMS AND CONSULTANT FORMS

In our Second Opinion Program under Plan business, the Consultant Report is imprinted on the back of the Statement of Service Claim Form.

This decreases bulk, as well as eliminates the possibility of consultation charges being submitted in the absence of a record of the consultant's findings and recommendations.

Since it was determined to be impractical to revise the SSA 1490 to include the Second Opinion Surgeon Findings on the back of the claim form, a separate consultant report sheet was developed.

In an effort to be assured that the report was returned to the Center with the claim form, permission was obtained from HCFA to staple the forms together back to back.

Forms Control

Since complete and accurate data is vital to the evaluation of this Experiment, all information on the Second Opinion Surgeon Report will be quality checked by the control clerk when received. Reports containing missing items that have been determined to be essential to the study, will be returned for completion.

Blue Cross
Blue Shield
of Greater New York

P.O. Box 551, Murray Hill Station
New York, New York 10016

PRESSO

PROGRAM FOR ELECTIVE
SURGICAL SECOND OPINION

Date: _____

Re: _____
(Patient's Name)

Dear Dr. _____

As you may be aware, Blue Cross and Blue Shield of Greater New York offers a Program for Elective Surgical Second Opinions to its subscribers and to Medicare Part B Beneficiaries under a demonstration project supported by the Health Care Financing Administration.

Briefly, the Program provides upon request, the benefit of a Second, and in some instances a Third Surgical Opinion, scheduled through our Referral Center.

More than 1500 Surgical Specialists on our Second Opinion panel are available to provide these consultations. They have signed an agreement which states that neither they nor their associates will perform surgery or otherwise treat any patient referred to them for consultation.

Your patient is seeking a Second Surgical Opinion, and has given us permission to ask you to release information regarding his/her medical history, which could be of value to the consultant. It will also be useful in evaluating the impact of the Program on cost containment and quality of care.

We would greatly appreciate it if you would complete the enclosed form, and return it in the pre-addressed envelope as soon as possible.

Thank you for your cooperation.

Sincerely,

Patricia O'Connor

Patricia O'Connor, Coordinator
Program for Elective Surgical
Second Opinion

POC:ac
Enclosure

Blue Cross
Blue Shield
of Greater New York

P.O. Box 551, New York, N.Y. 10016

SURGICAL SECOND OPINION PROGRAM
FIRST OPINION SURGEON REPORT

BENEFICIARY NAME			HIC NUMBER	
STREET ADDRESS	COUNTY	STATE	ZIP CODE	APARTMENT

TO BE COMPLETED BY FIRST OPINION SURGEON

DIAGNOSIS (STANDARD NOMENCLATURE PLEASE)	CODE *
HISTORY AND FINDINGS OR SIGNIFICANCE	

WAS SURGERY RECOMMENDED 1 ☐ YES 2 ☐ NO	IF YES, PROCEDURE	CODE

IF SURGERY IS RECOMMENDED TO TREAT A MALIGNANCY, WAS A BIOPSY DONE? 1 ☐ YES 2 ☐ NO	IF BIOPSY WERE DONE, WERE RESULTS POSITIVE? 1 ☐ YES 2 ☐ NO	IF NOT DONE, PLANNED? 1 ☐ YES 2 ☐ NO

PLACE WHERE SURGERY WOULD BE PERFORMED 1 ☐ HOSP. IN PT. 2 ☐ HOSP. O.P.D. 3 ☐ M.D. OFFICE 4 ☐ OTHER (SPECIFY)	IF IN HOSPITAL, PLEASE GIVE NAME OF INSTITUTION	CODE
IF SURGERY NOT RECOMMENDED, PLEASE STATE TYPE OF SURGERY DISCUSSED		
		CODE

TYPE OF PRACTICE 1 ☐ SOLO 2 ☐ GROUP	PHYSICIAN'S SIGNATURE	DATE OF EXAMINATION

The authority for collecting the above information is contained in section 402(a) of the 1967 Amendments to the Social Security Act, as amended by section 222(b) of the 1972 Amendments to the Social Security Act, P.L. 92–603. Disclosure of such information is voluntary.

The information on this form will be used to aid consultants in evaluating the beneficiary's condition and to evaluate the impact of the program. If individuals do not provide the information, consultant opinions will lack background on the beneficiary which only the first opinion surgeon can provide and evaluation will be impaired. However, non-disclosure will not personally affect the first opinion surgeon.

*Codes for BCBSGNY use only

HCFA-37T

Blue Cross
Blue Shield
of Greater New York

MEDICARE
622 Third Avenue New York N Y 10017

Date _____

Dear BENEFICIARY

Attached is a Medicare Payment Form for you to complete. Please do not detach it from the Consultant's Report.

Fill in items 1 - 6 and take the stapled form with you to see your Second Opinion Surgeon.

Your appointment has been scheduled with

Dr.: [redacted]

Address: [redacted]

Phone: [redacted]

on the following date and time [redacted]

The surgeon will complete the remaining portion of the form and mail it back to us. We will then pay him directly. There will be no charge to you for this second surgical opinion.

Should the doctor want you to have an x-ray or some laboratory tests done outside his office, please call me at 481-2658 for further instructions.

If you are unable to keep your appointment, please call the surgeon as soon as possible, and then notify me.

Please Note: THIS SECOND OPINION SURGEON CANNOT PERFORM SURGERY OR OTHERWISE TREAT YOU.

Sincerely,

_____, Referral Analyst

REQUEST FOR MEDICARE PAYMENT

MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT (See Instructions on Back—Type or Print Information)

Form Approved OMB No. 72-R0730

NOTICE—Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal Law.

PART I—PATIENT TO FILL IN ITEMS 1 THROUGH 6 ONLY

When completed, send this form to:
Blue Cross and Blue Shield 00803
of Greater New York
622 Third Avenue
New York, New York 10017

Copy from YOUR OWN HEALTH INSURANCE CARD (See example on back)

1 Name of patient (First name, Middle initial, Last name)

2 Health insurance claim number (Include all letters)

☐ Male ☐ Female

3 Patient's mailing address | City, State, ZIP code | Telephone Number

4 Describe the illness or injury for which you received treatment (Always fill in this item if your doctor does not complete Part II below)

Was your illness or injury connected with your employment? ☐ Yes ☐ No

5 If any of your medical expenses will be or could be paid by another insurance organization or government agency (including FEHB), show below.

Name and address of organization or agency | Policy or Identification Number

Note: If you Do Not want information about this Medicare claim released to the above upon its request, check (X) the following block ☐

6 I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

Signature of patient (See instructions on reverse where patient is unable to sign) | Date signed

SIGN HERE

PART II—PHYSICIAN OR SUPPLIER TO FILL IN 7 THROUGH 14

7 A. Date of each service	B. Place of service (*See Codes below)	C. Fully describe surgical or medical procedures and other services or supplies furnished for each date given — Procedure Code	D. Nature of illness or injury requiring services or supplies (diagnosis)	E. Charges (If related to unusual circumstances explain in 7C)	Leave Blank
				$	

MEDICARE PART B
SECOND SURGICAL OPINION
EXPERIMENT

8 Name and address of physician or supplier (Number and street, city, State, ZIP code)

Telephone No.

9 Total charges $

Physician or supplier code

10 Amount paid $

11 Any unpaid balance due $

12 Assignment of patient's bill
☐ I accept assignment (See reverse) ☐ I do not accept assignment.

13 Show name and address of person or facility which furnished service (if other than your own office or patient's home)

14 Signature of physician or supplier (A physician's signature certifies that a physician's services were personally rendered by the physician or under the physician's personal direction).

Date signed

*O—Doctor's Office
IL—Independent Laboratory
H—Patient's Home (If portable X-ray services, identify the supplier)
IH—Inpatient Hospital
SNF—Skilled Nursing Facility
OH—Outpatient Hospital
OL—Other Locations
NH—Nursing Home

FORM SSA 1490 (11-75)

Department of Health, Education, and Welfare
Social Security Administration

Blue Cross
Blue Shield
of Greater New York

P.O. Box 551, New York, N.Y. 10016

SURGICAL SECOND OPINION PROGRAM
CONSULTANT'S REPORT

HIC NUMBER

CONSULTANT'S DX (STANDARD NOMENCLATURE)		CODE *
		CODE
NEED FOR SURGERY 1. ☐ CONFIRMED 2. ☐ NON-CONFIRMED	IF NEED FOR SURGERY IS CONFIRMED, PROCEDURE RECOMMENDED	CODE
		CODE

SURGERY NOT RECOMMENDED BECAUSE: (CHECK ONE OR MORE AS INDICATED)

1. ☐ NO TREATMENT IS NECESSARY
2. ☐ NO PATHOLOGY FOUND
7. ☐ OTHER
3. ☐ A TRIAL OR MEDICAL MANAGEMENT IS INDICATED
   A. ☐ MEDICATION C. ☐ DIET THERAPY
   B. ☐ P.T. D. ☐ OTHER
4. ☐ COMPLICATING CONCURRENT CONDITIONS PRESENT (SPECIFY)
5. ☐ RE-EVALUATION INDICATED
6. ☐ FURTHER DIAGNOSTIC STUDIES INDICATED

CONSULTANT'S REMARKS

RECOMMENDED LOCATION FOR SURGERY

1 ☐ HOSP. INPATIENT 2 ☐ HOSP. O.P.D. 3 ☐ M.D. OFFICE 4 ☐ OTHER

PLEASE LIST ANY LAB TESTS ORDERED	CODE	RESULTS	CODE
1		1	
2		2	
3		3	

REASON FOR ORDERING LAB TESTS OR X-RAYS

1 ☐ DID NOT RECEIVE FIRST SURGEON'S REPORT
2 ☐ UPDATED RESULTS REQUIRED
3 ☐ EXISTING REPORTS INCONCLUSIVE
4 ☐ EXISTING RESULTS NEEDED VERIFICATION
5 ☐ OTHER

BY OBSERVATION, PLEASE STATE PATIENT'S ETHNICITY

1 ☐ WHITE NOT OF HISPANIC ORIGIN 2 ☐ BLACK NOT OF HISPANIC ORIGIN 3 ☐ HISPANIC 4 ☐ AMERICAN INDIAN 5 ☐ ALASKAN NATIVE 6 ☐ ASIAN OR PACIFIC ISLANDER

DID YOU DISCUSS YOUR FINDINGS WITH THE FIRST SURGEON? ☐ YES ☐ NO

SIGNATURE	DATE SIGNED

The authority for collecting the above information is contained in section 402(a) of the 1977 Ammendments to the Social Security Act as amended by section 222(b) of the 1972 Ammendments to the Social Security Act, P.L. 92-603. Disclosures of such information is voluntary.

The information collected on this form will be used to evaluate the impact of the program. If individuals do not provide the information their agreement as a participating consultant may be terminated with 30 days notice.

*Codes for BCBSGNY use only

HCFA-38T

PRES 22 (3-78)

Blue Cross
Blue Shield
of Greater New York

622 Third Avenue, New York, N.Y. 10017

PRESSO

PROGRAM FOR ELECTIVE
SURGICAL SECOND OPINION
(212) 481-2658

Date _____

Re: _____

Date of Service: _____

Dear Doctor _____:

Thank you for seeing the above patient referred by the Second Surgical Opinion Center of Blue Cross and Blue Shield of Greater New York.

Unfortunately, we are unable to process the attached claim form as presently completed.

Would you please provide us with the following information, so we may reimburse you for your services.

° Patient's diagnosis _____

° The specific type of surgical procedure recommended _____

° Recommended location for surgery _____

° Reason surgery is not recommended _____

° Your signature _____

Thank you.

Sincerely,

Patricia O'Connor

Patricia O'Connor, Coordinator
Program for Elective
Surgical Second Opinion

POC:jmb

PROGRAM SPECIFICATIONS

During the course of planning for the System's Modifications necessary to process Part B Experimental Claims, several approaches were designed and evaluated.

Each was balanced against budgetary considerations, resource availabilities and anticipated claims volume.

The Specifications for the System we have elected to implement are included in this Protocol. However, we felt it appropriate to make available a brief description of each of the alternatives we considered.

The following, then, summarizes these approaches.

APPROACH I

Extensive Use Of The Computer Using The SSA Type Of Service Codes To Identify The Second Opinion Experimental Claims

Under this approach the Second Opinion Referral Center was responsible for:

° Insuring that the beneficiary met the eligibility criteria under the program, i.e., he has seen a surgeon.

° Insuring that the beneficiary was eligible for Medicare Part "B" coverage.

° Arranging for the Second (or Third) Opinion Consultation.

Medicare Claim Operations was responsible for:

° Assigning an ICN and microfilming the claim form, batching it and entering it into the control system.

° Entering the claim data into the system.

° Resolving and reprocessing Green and Blue Sheet suspense items.

The Medicare "B" System would process the claim. In this regard, the following should be noted. The system would:

° Reverify the beneficiary's Medicare Part "B" eligibility, using any prior claims which may be available or generating a "Z" query to Baltimore.

° Compute the pricing of consultation services.

° Audit the pricing of Pathology and Radiology services.

° Check for and prevent the payment of duplicate claims.

Based on these specifications, programming time and costs would be considerable. For this reason, the following was considered.

APPROACH II

Extensive Use Of The Computer Using Unique Batch Numbers In Lieu Of The SSA Type Of Service Codes

Under this approach the procedures and responsibilities of the Referral Center and Medicare Claim Operations would remain essentially the same. The only change would be that claims would have to be sorted by the Referral Center and processed by Medicare Claim Operations under the unique batch numbers. The Green and Blue Sheets for the Experimental Claims would be identified by the unique batch numbers instead of the unique Type of Service codes.

Although the specifications changed in regard to how the Experimental Claims would be identified, the system would still perform all of the functions described in Approach I.

Despite the fact that the estimated programming time and costs were reduced by this method, they were still extensive. Therefore, a third alternative was explored.

APPROACH III

Transfer Of Functions From The Automated System To The Manual System

Under this approach, the Medicare "B" Automated System would not:

° Verify the beneficiary's Medicare Part "B" eligibility.

° Perform any claim pricing calculations or audits.

° Check for duplicate claims.

Accordingly, these functions must be incorporated into the Manual system:

° Verification of beneficiary's Medicare Part "B" eligibility.

  ° This would become the responsibility of the Referral Center, who would verify the beneficiary's Part "B" coverage immediately prior to processing the claim for payment. This would be accomplished by processing a "Status Query" via the Medicare Model "A" System.

° Claim pricing.

  ° The additional work involved would be absorbed by Medicare Claim Operations. The Second Pass Area would be responsible for manually reviewing all Experimental Claims prior to payment and determining if they have been processed correctly.

° Check for duplicate claims.

  ° The Second Opinion Center will be solely responsible for insuring that duplicate Experimental Claims are not paid. The beneficiary's claim folder would be used as the source to establish that the same case is not paid twice. (Copies of all Experimental SSA 1490 Claims previously paid are kept in the patients record in the Referral Center.) No case will be processed for payment if a Second Opinion claim already exists.

    In addition, the beneficiary's claim history will be checked, via CRT, before the claim is sent for payment. This is done to insure that the beneficiary has not also filed another claim for the same date of service.

This approach appreciably reduced programming time and costs. Nonetheless, it was decided to explore the possibility of processing the cases outside of the Medicare Part "B" production system.

APPROACH IV

An Almost Totally Manual System With A Small Automated System To Produce The Checks and EOMB's As Well As Collect Statistics

This approach was considered to further reduce the EDP costs. While the ENTREX System, which would be used to capture the claim data on tape, could perform some basic validations (missing data, maximum payment amounts, etc.), the bulk of the work would be done manually. This would require:

- checking various listings to insure that the Providers and beneficiaries are valid and Medicare eligible.
- auditing the claims to insure that they were coded correctly.
- establishing that accurate payments were made before the checks were released.

Some of the major problems which were uncovered were:

- New Bank reconciliation procedures would have to be developed.
- The Programming Staff has advised us that there are no facilities to interface a tape into the payment processing part of the Medicare Part "B" System. Also, it is not possible to add this claim data to the payment tape. In order to append data to the payment tape, the claim must be entered into the front end of the system. Therefore, provisions would have to be made for a separate payment record tape.
- The cost of modifying the system to carry the claim through, without performing any of the established system functions, has been estimated to be higher that the cost to modify the system as outlined in Approach I.
- The Experimental Claim data would not be appended to the Medicare Part "B" System History Files and therefore not available (via CRT) to the various departments which deal directly with the beneficiaries.
- Increased Second Opinion Center staffing would be necessary.
- There would be a cost to design, develop and program the ENTREX System and the automated system to:
  - produce the checks.
  - produce the EOMB's.
  - collect the claim statistics.

APPROACH V

Total Manual Processing

Although RFP was predicated upon computer processing, we reviewed the possibility of utilizing a manual system to process the claims. In this regard the following should be noted:

- The Accounting Department advised us that no Medicare funds could be used to pay claims unless the claim data is reported to the SSA via the payment system. While a manual, or fast check may be drawn in unusual circumstances, eventually, the claim data must be appended to the payment tape which is sent to Baltimore.

- If the claim is not processed in the system no information will be available via CRT. This will hamper the ability of the Center, Medicare Correspondence, Telephone and Interviewing Departments to efficiently service the beneficiaries.

- Experimental Programs' claim history which must be available on tape modes for the evaluator could not be obtained.

- The manual system does not provide sufficient controls to insure that claims are paid properly.

- The manhours which would be required to manually prepare reports would be substantial.

In summary, the more computer involvement there is, the faster and more accurately the claims are processed. On the other hand, as stated previously, this has to be balanced against budgetary considerations, resource availability, and anticipated claim volume.

On this basis, APPROACH III was selected. The following describes the specific modifications involved in revising the Part "B" System to process these Experimental Claims using this approach.

CHANGES REQUIRED TO THE MEDICARE B SYSTEM TO PROCESS SURGICAL OPINION EXPERIMENTAL PROGRAM CLAIMS

General Information

° The Beneficiarys' deductible and coinsurance responsibilities do not apply to Medicare Part B Second Surgical Opinion Experimental Program claims.

° The claims must be uniquely identified to facilitate manual and computed processing and to adhere to the SSA requirements.

° Payment will be made to either the Provider of Services or the Beneficiary.

° The claim documents and the tape records must be retained by BCBSGNY for ten years.

Claim Identification

The Medicare Part B Second Surgical Opinion Experimental Program claims will be assigned special "Batch Numbers". These numbers have been reserved for the processing of these claims only.

The "Batch Number" is part of the Internal Control Number (ICN) which is assigned to every Medicare claim. It consists of a Region Code, a Julian Date, the Batch Number and a claim sequence number. In regard to the Experimental Program two Batch Numbers (767 and 768) have been assigned to Second Opinion claims and one Batch Number (769) has been assigned to Third Opinion claims.

The normal Medicare Procedure and Type of Service codes will be used to process these claims. However, before the payment records are sent to the SSA, the Type of Service codes will be converted to conform with the SSA requirements. The conversion is based on the Type of Service and the Batch Number.

BCBSGNY		SSA	DESCRIPTION OF SERVICE
TYPE OF SERVICE CODE	BATCH NUMBERS	TYPE OF SERVICE CODE	
9	767&768	S	Second Opinion Consultation
9	769	T	Third Opinion Consultation
5	768&768	U	Second Opinion Radiology
5	769	V	Third Opinion Radiology
8	767&768	W	Second Opinion Pathology
8	769	X	Third Opinion Pathology

The following controls will be implemented to insure the Second Opinion Experimental Claims are coded correctly:

Consultation Services

° If the "Batch Number" is equal to one of the batch numbers which have been reserved for the Second Opinion Experimental Program and the Type of Service Code is "9" the procedure codes can only be one of the following:

9054
9055
9057
9058
9008
9009
9063

° If the "Batcn Number" is equal to one of the batch numbers which have been reserved for the Second Opinion Experimental Program and the "Procedure Codes"are equal to either 9054, 9055, 9057, 9058, 9008, 9009 or 9063, the "Type of Service Code" must be equal to "9".

Radiology and Pathology Services

If the "Batch Number" is equal to one of the batch numbers which have been reserved for Second Opinion Experimental Program claims and the procedure code is not equal to one of the "Consultation" procedure codes:

° The "Type of Service Code" must be equal to "5" or "8".

Establishing Beneficiaries Part B Eligibility

Before the claim is entered into the Medicare B System, a status query will be sent to the SSA via the Model "A" system.

The "Medicare B System" will bypass eligibility processing. The System will not utilize it normal routines for establishing the Beneficiarys' eligibility from prior claims. The System will not query SSA for the patients eligibility.

When a Second Opinion Experimental Claim is entered, the Medicare B System will generate a "Beneficiary Eligible" code and a "Deductible Met" status on the claim transaction.

Claim Pricing

The System will bypass its usual pricing routines and pay whatever amount is on the input transaction. The controls will consist of maximum dollar amounts which can be entered and a 100% audit of the claims via the "Blue Sheet" procedures.

° Payment for Consultation (Initial Data and Green Sheet)

  ° If the "Batch Number" is equal to one of the batch numbers which have been reserved for Second Opinion Experimental Claims and the "Type of Service" code is equal to "9" and the "Procedure Code" is equal to one of the specific codes allowed for this procedure, the System will not allow a payment in excess of $50.00 to be entered.

° Payment for Pathology and Radiology (Int. Data and Green Sheet)

  ° If the "Batch Number" is equal to one of the batch numbers which have been reserved for Second Opinion Experimental Claims and the "Procedure Code" is not equal to one of the "Consultation" procedure codes and the "Type of Service" code is "5" or "8" the System will not allow a payment in excess of a predefined amount to be entered.

° Audit of Experimental Claims

  ° The System will suspend all Second Opinion Experimental Claims as "Blue Sheets". All data on the claim will be reviewed before the claim is processed for payment. The original claim document (SSA 1490) will be checked against the System generated "Blue Sheet" by senior, well trained, responsible personnel. Based upon this review, one of the following maintenance transactions are processed.

    1. Pay claim as is.

    2. Delete claim.

    3. Pay claim with corrected data (No System validation).

Payments to Provider or Beneficiary

° Consultation Services

  ° Payment will usually be made to the Provider. However, in some instances, payment could be made to the Beneficiary.

° Radiology and Pathology Services

  ° It is anticipated that for these services as many payments will be made to the Beneficiaries as are made to the Providers.

Queens Physicians

There are approximately 1300 board certified surgeons cooperating on the Second Opinion Panel in the 17 counties of Greater New York area. Some of these physicians are located in Queens County and are normally services by G.H.I. BCBSGNY will process the claims submitted by these physicians under this Experimental Program.

The Medicare B System validates each Provider as it processes the claims to insure that the Provider is authorized to receive Medicare payments. An additional step will be added to this Program. If the Provider is not Medicare eligible the System will check the Batch Number before rejecting the case. If the claim contains one of the Second Opinion Experimental Batch Numbers the claim will be processed for payment.

Utilization Review

The normal utilization review routines will be suspended for Second Opinion Experimental Program Claims; this includes the System validation parameters to prevent two Consultations claims from being paid within six months of each other.

The System will bypass the utilization review sub-system for all claims which contain the Second Opinion Experimental Claim Batch Numbers.

Green Sheets and Blue Sheets (Error Notices)

The Green Sheets and Blue Sheets relating to Medicare Part B Second Surgical Opinion Experimental Program claims will be identified by the Second Opinion Experimental Claim Batch Numbers.

Quality Assurance (Q.A.) Systems

The SSA has advised that Medicare Part B Second Surgical Opinion Experimental Program Claims should be excluded form Q.A. review.

On this basis, the HBOJ250N program must be modified to exclude these claims. The Batch Numbers which have been reserved for the Experimental Claims will be used to identify the claims to be excluded.

Maintaining Second Opinion Claim History

In addition to all of the normal processing, a separate payment tape file will be maintained for Second Opinion Claims.

° The file format will be the same as the "Pending Master File".

° The file will be updated daily.

° The SSA has advised that Beneficiaries who are under age 65 and are covered under HR-1 need not be specifically identified on the Claim History File.

° The claim data on this file will reflect the SSA Type of Service Codes (S, T, U, V, W and X).

° This file will be used to meet our obligations to maintain Medicare Part B Second Surgical Opinion Experimental Program Claim history for ten years.

° This file will also be used to prepare reports as required.

Security

In order to insure that Second Opinion paid claim data is available and can be retrieved in case of a disaster, a copy of the Medicare Second Opinion Claim History File will be kept offsite.

At the end of the first week of processing and every week thereafter the current Medicare Second Opinion Claim History File will be copied and placed in the BCBSGNY Offsite Tape Library. The offsite tape from the previous week will be scratched and returned to the 622-3rd Ave. Tape Library.

Notation of the EOMB

The notation "Second Opinion" will be appended to the EOMB for all claims with a Second Opinion Batch Number.

Payment to Providers

The payment for Medicare Part B Second Surgical Opinion Experimental Program claims will be included on the normal Summary Checks which are sent to the Providers.

CRT Information

The notation "SO" will be reflected on the CRT screens to identify Medicare Part B Second Surgical Opinion Experimental claims.

Duplicate Claim Validation

The Second Opinion Research Center is responsible for identifying and rejecting duplicate Second Opinion Experimental claims. The Medicare B System will not check for duplicate claims.

Before any experimental claim is released for payment, the CRT in the Second Opinion Center will be checked to establish if an "I.L. Routine Claim" has been submitted for the same date of service.

Before an I.L. Second Opinion Claim is processed, the system will check to see if a "Second Opinion Experimental Claim" has entered into the system for the same date of service.

Payment Records to SSA (Payment Summary File)

Currently we convert Type of Service codes Ø, A, B, P, R, S and C to 5, 1, 5, 9, 9, 9 and Ø on the payment data we send to the SSA. In regard to the Medicare Part B Second Surgical Opinion Program claims, the SSA has mandated an "S" through "X" sequence of codes be submitted. Based on the Batch Number, the BCBSGNY Type of Service Code will be converted to the required SSA Type of Service Code.

Conversion Table for Type of Service Code

BCBSGNY PROCESSING	(BATCH #'s)		PAYMENT RECORDS TO SSA
9	(767&768)	=	S
9	(769)	=	T
5	(767&768)	=	U
5	(769)	=	V
8	(767&768)	=	W
8	(769)	=	X

Payment Record Reference File (PRRF)

No changes are required to these programs.

Tape-to-Tape Processing

Because of the unique data collection mechanism employed in this Experiment, all claim forms channel through the Second Opinion Referral Center prior to entering the routine processing mechanism.

Accordingly, no Second Opinion Experimental claims can be processed via the tape-to-tape billing arrangements, even though the provider is participating in a tape-to-tape program.

Reports

The Second Opinion Experimental claims will not be distinctively identified on the Monthly Intermediary Financial Report (SSA 1522).

The BCBSGNY Accounting Department will be supplied with the paid data pertaining to the Experimental Claims.

No other special reports are anticipated.

Control System

No changes are required in the Control System.

Profile Generation

A decision has been made not to include these Experimental File Claims in the Provider File Profile computations.

Payment Record Rejections

The attached memo from Lewis A. MacKinnon in Medicare Part B Systems (HCFA) expresses his concurrence with our proposed Part B System Modification.

The memo includes instructions to be followed should any payment records submitted under the experiment be rejected.

From a manual and automated systems stand point, there are no problems in adhering to these instructions. Though we do not anticipate rejections because of the control procedures developed, the following addresses each potential reason for rejection and describes the payment record reject corrections that would be employed should they occur.

I. Code "9" Reject

The BCBSGNY Medicare Part B System will append a code "9" in the high order position of the deductible field at the same time it converts our internal Type of Service codes to the S-X HCFA codes. On this basis, BCBSGNY should not have a Medicare Part B Second Surgical Opinion Experimental claim rejected because the "9 code" is missing. However, if it should happen, the claim will be adjusted in accordance with Section 13071.3-A.1. of the Medicare Carriers guide.

II. Reject Because Consultation Charges or Reimbursement Amount Exceeds $50

When the claim data is initially entered the BCBSGNY Medicare Part B System will not accept a charge in excess of $50 for Consultation Services. This is accomplished through a series of validations:

- If a Type of Service Code "9" (Consultation) is entered the system will only accept specific (consultation) Procedure codes. If these two codes are not compatable the system will not accept the transaction.

- If a Consultation Procedure code is entered, the system will not accept the transaction unless the Type of Service code is "9".

- If the Type of Service code is "9" and the Procedure code is for a consultation, the system will not accept the transaction if the charge exceeds $50.

After the manual Blue Sheet audit, the $50.00 charge can only be increased (or decreased) by the use of a specific unique transaction code. When this code is used, it must be accompanied by a "reason" code. The point being, that it is unlikely that the amount will be changed by mistake.

However, if it should occur, the payment reject will be adjusted in accordance with Mr. MacKinnon's letter.

III. Reimbursement at 80% of the Reasonable Charges and the Type of Service Code is S-X

It is virtually impossible for this to happen.

- The BCBSGNY Medicare Part B System converts the inhouse Type of Service codes to the HCFA Type of Service codes only when the claim is processed under Batch Numbers 767, 768 or 769.

- When a claim is processed under Batch Numbers 767, 768 or 769 the BCBSGNY Medicare Part B System is designed not to price the claim. Instead, it pays 100% of the amount which was input.

- There is no reason the believe that at the time of Blue Sheet audit the clerk would mentally calculate 80% of the charges. Aside from being against established procedures for processing the Experimental claims, it is not something they do when processing regular Medicare claims.

However, if it should occur, the payment record reject will be processed in accordance with the instructions in Mr. MacKinnon's letter.

IV. Medical Charges and Reimbursement Amount are Not Equal (Directive from Mr. Fraher)

The following is done at BCBSGNY to prevent this:

- The Second Opinion Referral Center adds the individual charges and compares the sum to the total bill as part of their claim examination procedure. Any discrepancies are corrected.

- If one of the charges are to be reduced, SORC makes the changes on the 1490 form before submitting if for payment.

- As part of our testing it was verified that the BCBSGNY Medicare Part B System adds each individual charge and compares the sum to the total bill. If there is a discrepancy the system will not accept the transaction.

However, if for some reason a claim is rejected by HCFA for this reason; the payment reject will be handled in accordance with the specifications in Mr. MacKinnon's letter.

From an automated system standpoint, the only change that had to be made is the appending of a code "9" in the high order position of the deductible applied field of the payment record.

No changes are required in the manual system for processing payment rejects.

APR 18 1979

TO: Trudi Galblum

SUBJECT: System Modifications for Second Opinion Experimental Program

We agree with the modifications proposed by Blue Cross and Blue Shield of Greater New York and by Blue Cross and Blue Shield of Michigan concerning the implementation of the subject experiment.

For your information, we are attaching a copy of our draft memorandum which furnishes the specifications necessary to enable our system to accept and process payment records generated as a result of this experiment. While the number of payment records generated under this experiment are expected to be few, some rejects may occur. Therefore, we request that you notify the above carriers that the corrective actions given below should be taken for payment records rejected under the experiment.

1. When the service was reimbursable under the experiment (i.e., the type of service is coded S-X) and the payment record was rejected because "9" was not recorded in the high order position of the deductible applied field, correct the record in accordance with the instructions given in Section 13071.A.1 of the Medicare Carriers Manual (MCM).

2. When the service was reimbursable under the experiment as consultation services (i.e., the type of service is coded S or T) and the payment record was rejected because the medical charges and/or the reimbursement amount ~~exceeds $50.00, correct the record in accordance with~~ Subsection A.2.b.2) of MCM Section 13071.3.

3. When the service was reimbursable under the experiment (i.e., the type of service code is 5-X) but was reimbursed at 80 percent of the reasonable charges, resulting in an underpayment:

   a. Adjust the medical charges in the payment record so that it equals the reimbursement amount (ensuring that a "9" is recorded in the high order position of the deductible applied field) and resubmit the record in a correction batch series.

   b. Issue a supplemental check to cover the underpayment.

   c. Prepare an entry code 2 (supplemental debit) payment record in the same amount as the supplemental check, show "9" in the high order position of the deductible applied field, and submit the record in a payment series batch. (See MCM Section 13099, Exhibits 22-22C, Table for Code C Rejects).

Lewis A. MacKinnon

Attachment

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3. Bunker, John P., and Brown, Byron, "The Physician-Patient as an Informed Consumer of Surgical Services,"New England Journal of Medicine, Vol. 290 (May 9, 1974)

4. Bunker, John P., and Wennberg, John E., "Operation Rates, Mortality Statistics, and the Quality of Life,"New England Journal of Medicine, Vol. 289 (Dec.6, 1973)

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7. Doyle, James C., "Unnecessary Hysterectomies: Study of 6,248 Operations in 35 Hospitals During 1948," JAMA, Vol. 151 (Jan. 31, 1953)

8. Doyle, James C., "Unnecessary Ovariectomies: Study Based on Removal of 704 Normal Ovaries from 546 Patients," JAMA, Vol. 148 (March 29, 1952)

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